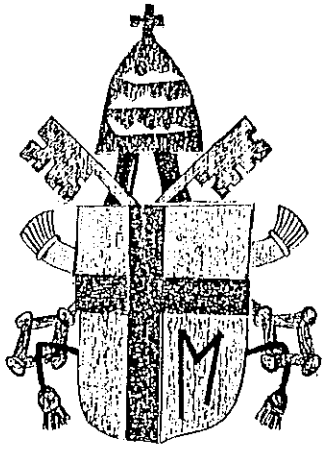

DOLENTIUM HOMINUM
No 15 (Fifth Year - No 3) 1990
JOURNAL OF THE
PONTIFICAL COUNCIL FOR
PASTORAL ASSISTANCE TO
HEALTH CARE WORKERS

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Vatican City
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Published three times a year

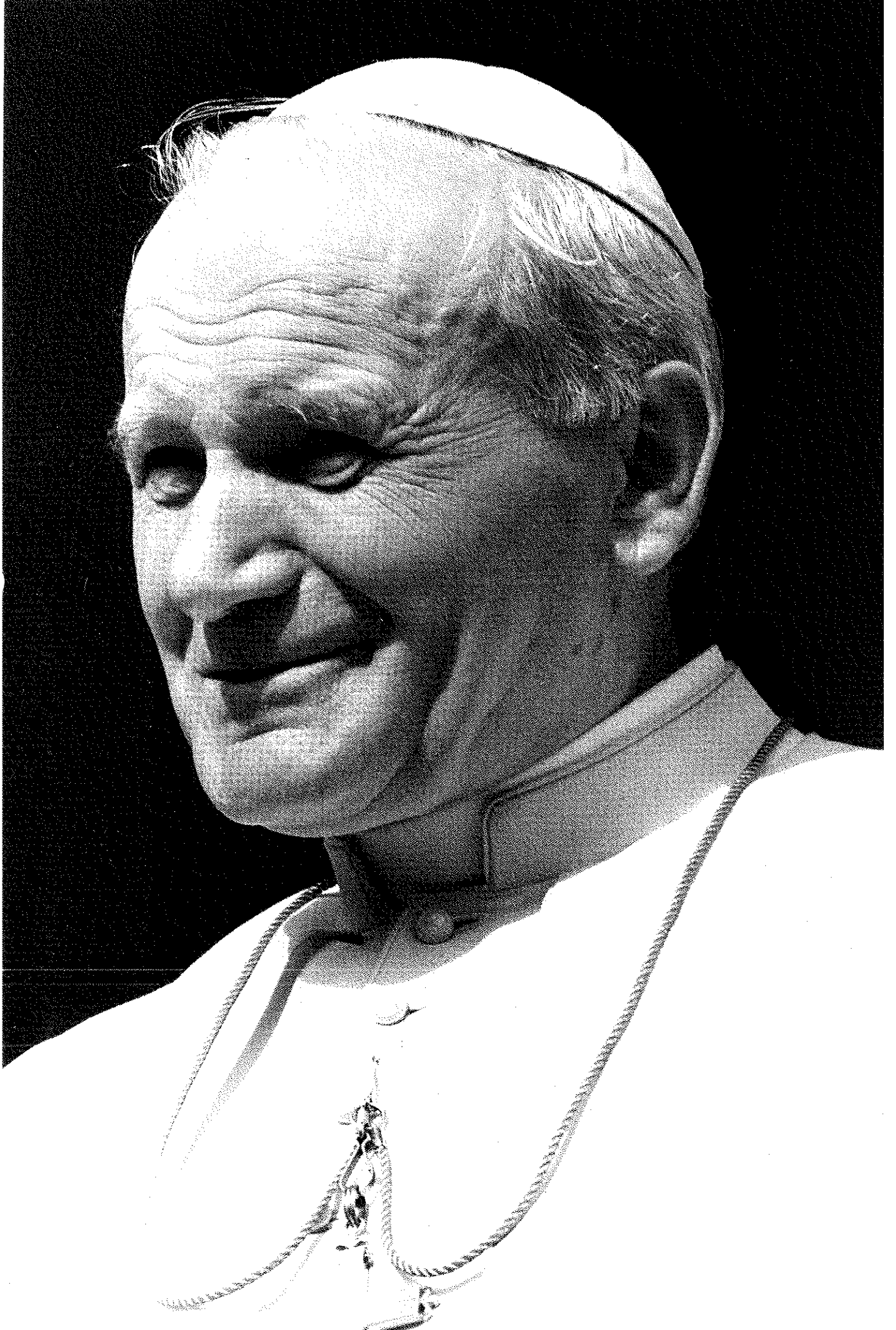
Subscription rate:
one year Lire 60,000
(abroad $ 60 or the corresponding
amount in local currency
postage included)

Printed by
Vatican Polyglot Press

Sped. in abb. post. gr IV/70%
III Quadrimestre 1990

Contents

The illustrations in this issue have been taken from Thadens Chrzanowski Oltarz maracki wita stwosza - *Ed. Interpress Warsawa 1985.*



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SERENISSIMAE REI PUBLICAE POLONORUM

NOS

THADDAEUS CICHOCKI

MEDICINAE DOCTOR,
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h.t. ORDINIS PROFESSORUM FACULTATIS MEDICAE
DECANUS SPECTABILIS

EX AUCTORITATE ORDINIS PROFESSORUM FACULTATIS MEDICAE
ET SENATUS ACADEMIAE

IN

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MEDICINAE DOCTORIS

HONORIS CAUSA

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ADAMUS SZYMUSIK
ORDINIS MEDICORUM DECANUS

THADDAEUS CICHOCKI
ACADEMIAE RECTOR
DOCTORIS PROMOTOR

Diploma of the Honorary Doctorate in Medicine, awarded to H.E. Msgr. Fiorenzo Angelini by Jagellons University in Cracow (Poland) on November 24, 1990

The Magisterium of John Paul II for Health Care Workers

Archbishop Fiorenzo Angelini's address at Jagellons University in Cracow, Poland when receiving an Honorary Doctorate in Medicine on November 24, 1990

Distinguished Chancellor of the first university in Poland, Jagellons University, founded in far-off 1364 by King Kasimirus, distinguished Rector of the Copernicus Academy of Medicine, Your Eminences, Cardinals Jozef Glemp, Franciszek Macharsky, and Henryck Roman Gulbinowecz, Your Excellency, the Apostolic Nuncio, the Honorable Minister of Health, Your Excellencies, the Bishops present, distinguished Members of the Academy Senate, distinguished Rectors of the university academies of Cracow, distinguished Professors, dear students, ladies and gentlemen.

It is for me a very great honor to be at this historic and noble University today, where Nicolaus Copernicus was a student of medicine and astronomy and where Pope John Paul II, when only ten years old, saw his older brother Edmund receive a degree in medicine, and where he himself began studies in Polish literature and later, after the last war, took up philosophy and theology studies.

With great simplicity I affirm that I am particulary glad to receive an honorary degree in medicine, though I feel I do not deserve such lofty recognition for my scientific, cultural, and pastoral work, which I have always regarded as a modest but impassioned service to Christ, the divine physician of souls and bodies; His Vicar on earth, the Pope; and the Church, teacher and "expert in humanity."

I cordially thank the organizers of this initiative, who have wished to establish this day, which, in view of its values, will perennially remain memorable for me.

Having been invited to deal, if only briefly, with a topic directly connected with the present ceremony, I have written a short essay on the subject of "The Magisterium of John Paul II for Health Care Workers."

I believe that a preliminary terminological specification is appropriate. The magisterium of John Paul II concerning the care of the sick and particularly with respect to health professionals falls within the domain of the Church's pastoral action. We are dealing with directives, often very specific ones, which take into account the multiple and increasingly complex ethical and moral problems posed by medicine as both science/research and practice. In what sense can we speak of real magisterium and thus of the authority of such teaching? Are we faced with directives endowed simply with moral authority in view of the prestige and authoritativeness of the source or with a doctrine and a teaching which involve the very mandate of the Pontiff as the Vicar of Christ and caretaker of the indefectibility of the doctrine of the faith?

The originality and importance of the magisterium of John Paul II in the area of the pastoral care of the sick are founded on a fact which must be stressed. Indeed, his pastoral directives on the subject rest upon a theology of suffering or, if you prefer, on a pastoral theology of health care, which the Holy Father, in many of his documents, has clearly illustrated. Hence the authority of his teaching on the subject, in my judgment, and the need to refer to it in exercising the profession and mission of health professionals—all those who, under different headings and with specific functions, perform their activity in the sphere of health policy and care in the service of preventive, diagnostic, curative, and rehabilitative medicine dealing with man in his physical, psychic, and spiritual integrity.

1. The Nature and Christian Meaning of Human Suffering

The theology of suffering is rooted in the mystery of the Incarnation and Redemption by Christ, a mystery which speaks through "Christ's death on the cross"—i.e., through "the inscrutable profundity of his suffering and abandonment."[1] And it is precisely Christ made man — and a Man of Sorrows — that makes the Church look to man as "her way,"[2] since as Christ redeemed the whole human race in becoming a man, so the Church, in becoming incarnate, continues the work of Christ. But in order for the incarnation to be full, Jesus chose to take on the condition of the least ones, the slaves, the weak, and the suffering. If, then, man is the way of the Church, he becomes such in a special way "when suffering enters his life."[3]

We may wonder how suffering can become an instrument of redemption if redemption is itself liberation from pain? Here is the answer in the clear teaching of John Paul II: "In working the redemption through suffering, Christ has at once elevated human suffering to the level of redemption. Every man, then, in his suffering, can also become a participant in the redemptive suffering of Christ."[4] The Good News of Christ, his Gospel, is thus for John Paul II a "Gospel of suffering." Indeed, "the witnesses of the Cross and the resurrection of Christ," the Holy Father writes, "have transmitted to mankind a specific Gospel of suffering. The Redeemer himself wrote this Gospel first of all with his own suffering taken on out of love so that man "will not die, but have eternal life "(*Jn* 3:16).[5]

Suffering is not just of the kind which bears the name of an illness, but suffering is the human condition. In speaking of human work, of whatever variety, John Paul II asserts, "Sweat and fatigue, which work necessarily entails in the present condition of humanity, offer the Christian and every man who is called to follow Christ the chance to participate in love for the work Christ came to perform. This work of salvation has taken place by means of suffering and death on the Cross. In bearing the fatigue of work in union with Christ Crucified for our sake, man collaborates in some measure with the Son of God in redeeming mankind. He shows himself to be a true disciple of Jesus by in turn bearing the cross each day in the activity he is called to perform."[6]

From this rigorously theological vision of the nature of suffering in the mystery of the redemption there derives its practical meaning, which the Church is called to live out and bear witness to.

In the Encyclical *Sollicitudo Rei Socialis*, while adopting an attitude of constructive hope, the Holy Father outlines the painful scenario of mankind's limitless sufferings due to attempts on life, violence, and injustice.[7] In the face of this situation, the basic pastoral orientation of the Church today is thus formulated: "In the loving, generous welcoming of every human life, especially if weak or ill, the Church is today living out a fundamental moment in her mission, all the more necessary the more a culture of death has become dominant."[8]

Solicitude towards those suffering in body and spirit is felt by the Church "as an integral part of her mission."[9] Such solicitude must be expressed according to this twofold orientation, which John Paul II borrows from the very example of Christ, who, he affirms, "has at the same time taught man to do good with suffering and to do good to those who suffer. Under this twofold aspect he has thoroughly revealed the meaning of suffering."[10]

I do not think that the core, the essential reference point for the pastoral theology of health care, could be expressed in a way that was at once more effective and concise. And allow me to stress that in this form of teaching and magisterium John Paul II reproposes and makes his own the kerygmatic theology which characterized the great catechesis of the leading Church Fathers: a theology which interprets the truths of faith in the mysterious implementation they have found in Christ and which they can also find in us if we live as Christ's followers. And it is certainly not by chance that in often referring to the exemplariness of Mary Most Holy, the perfect disciple of Christ, John Paul II sees the synthesis of such following in the Mother, who associated herself with the passion and death of her Son.[11]

2. Practical Indications for Health Professionals

The Holy Father's pastoral orientations for health care workers are themselves inserted directly into his theology of suffe-

ring. For John Paul II, who is the health care worker? The Pope takes his definition from the Gospel when he states, "The parable of the Good Samaritan also belongs — organically — to the Gospel of suffering. . . . It indicates what the relationship of each of us with our suffering neighbor must be like." [12]

The health worker is one who is close to his suffering neighbor to bring him relief and comfort. Moreover, no profession or mission, no positive activity is found so often in the Gospel as is attention to the suffering.

The first Pope to devote such a broad and authoritative document to the subject of suffering,[13] John Paul II continually refers therein to the example of Jesus, who, in his pastoral ministry, gave priority to approaching the sick and suffering. Indeed, wishing to draw near to the whole man and to all men, the Lord did so in that which principally joins them: suffering and the desire for physical, psychic, and spiritual health.

There is, however, a detail to be pointed out: in the field of suffering and solicitude for the sick, the magisterium and the ministry of John Paul II are united and fused. Teaching is constantly accompanied by practice. Indeed, almost as if to symbolize this exemplary synthesis, by a mysterious divine design, the Holy Father found himself embodying the condition of extreme suffering, brushing aginst violent death on the dramatic afternoon of May 13, 1981.

Before recalling John Paul II's practical indications for health professionals, then, it should first be specified that the doctrinal foundation for such indications involves the serious duty on the part of the health worker of being familiar with the Holy Father's magisterium.

In the Holy Father's practical indications for health workers, I would distinguish a twofold dimension: preparation and qualification, sustained by a community spirit.

Preparation

Rigorous professional and ethical-moral training is required for health care workers: doctors, researchers, pharmacists, nurses, volunteer personnel, administrators, technicians, men and women religious, and priests looking after the sick.

The right to health and, therefore, to health care, is a primary, fundamental human right.[14] At the same time, John Paul II confirms, "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." [15]

Proper professional training is not something separate from ethical-moral preparation since bioethics touches upon problems relating to man's birth, growth, development, to the safeguarding of his integrity, to life's natural close. Problems inseparable from the exercise of the health profession, as was, furthermore, confirmed at the recent Synod of Bishops.[16]

The continual insistence in John Paul II's magisterium on the sacredness of life and his firmness in opposing every form of attempt on life, from abortion to euthanasia, call for the necessity and urgency of having the preparation of health workers at all levels include bioethics as a required subject. Its development is closely linked to the increasingly interdisciplinary character of medicine. Science and technology have made great progress, but not everything which is scientifically and technically feasible is morally licit and thus acceptable.[17] More and more often the health professional is interpellated by the moral nature of his action. He must be prepared to answer all these questions.

Requirements

An initial practical requirement of the Catholic health worker flows from the

foregoing. *Complete fidelity to the Magisterium of the Church* is required of him or her; the Church is so conscious of this duty that she has made pronouncements, particularly in our time, with great clarity on the central themes of the defense and promotion of life. On the problems of responsible parenthood, so-called family planning, euthanasia, genetic experimentation, transplant surgery, prevention in the face of new social diseases, the Church has spoken out very clearly, offering directives not subject to debate, which are to be found frequently and firmly throughout the magisterium of John Paul II. The duty of being familiar with it, in view of the widespead materialistic and consumeristic mentality, is not only serious, but even urgent.

A second requirement concerning all health professionals is the ability to make a *humanized and humanizing* impression upon their profession. "Their task," as the Holy Father states, "cannot be limited only to correct professionalism, but must be sustained by the inner attitude which is fittingly called a "spirit of service"..... It is in this sense that the call to humanize is made..... This humanization means proclaiming the dignity and sacredness of life and of the human person, with respect to man's corporeality, spirit, culture, and sensibility."[18]

In the appeal to health professionals made by John Paul II in the Allocution closing the Fourth International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers, devoted to the subject of AIDS, the Holy Father outlined in the loftiest fashion the humanizing character of the service required of health workers.[19]

Another requirement directly concerning Catholic health professionals and all wishing to draw inspiration from the Christian faith involves pointing out professionally "the Christian identity of their service. Such an identity embraces the activity of individuals and associations, which in fact is linked to that of everyone — priests, religious, and lay people — engaged in the pastoral care of the sick. In reality, not a few aspects of this pastoral care coincide with the problems and tasks of the service to life performed by medicine.[20] Indeed, the Holy Father speaks of a "necessary interaction between the exercise of both in man, understood in his dignity as a son of God, a brother just like us needing help and comfort."[21]

Finally, as the Holy Father has confirmed on several occasions, the health worker who sees himself with a Christian identity in his profession and mission needs to give *open testimony*, particularly within the hospital community. It is not testimony leading to division, but which, in drawing sustenance from the principles of natural ethics and Christian morality, can foster maximum cooperation.

In this very Assembly Hall of the Collegium Maius of this prestigious Jagellons University of Cracow, on June 22, 1983 John Paul II vindicated Christian culture's strength and capacity to be a factor safeguarding and promoting culture in its broadest meaning — that is, as wisdom, knowledge, and righteousness.[22]

For the first time in the history of the Church a pontiff has created an office directly and exclusively devoted to the vast field of health policy and care. In instituting the Pontifical Council for Pastoral Assistance to Health Care Workers, over which I have the honor to preside, John Paul II has not only recognized the primary importance of the pastoral care of the sick, but has created an instrument involving the Church directly, at its highest level, in this field. As clearly indicated in the document instituting this Office of the Roman Curia, its aims are: "1) To stimulate and promote the work of formation, study, and action carried out by the different Catholic International Organisms in the health field, in

addition to that of other groups, associations, and forces which, on different levels and in varied ways, work in this sector; 2) coordinate the activities carried out by the different offices of the Roman Curia in relation to the world of health and its problems; 3) disseminate, explain, and defend the Church's teachings in the health area and foster their penetration into health practice; 4) to maintain contacts with the local Churches and particularly with the Bishop's Commissions for Health; 5) to follow closely and study program orientations and specific initiatives in health policy both internationally and nationally for the purpose of grasping their relevance and implications for the Church's pastoral care." [23]

The welcome received in the world of health policy and care by the Holy Father's initiative, the intense activity carried out by the Pontifical Council for Pastoral Assistance to Health Care Workers in its first five years of existence, its presence in promoting and stimulating both inside and outside the Church, its daily effort of service to all the Catholic health insitutions working in the world offer a global picture and — I would like to state — a visible foundation for the relevance and effectiveness of John Paul II's magisterium directed at Health Care Workers.

10

Conclusion

I have limited myself to simple allusions to the outlines of John Paul II's magisterium for health professionals. His authoritative statements, his familiarity with the world of suffering and health, his attention to the problems of medical ethics and bioethics, his continual contacts with hospital and care facilities and the sick allow us to affirm that his teaching for health workers represents a program, a complete formative itinerary for all working in the field of health policy and care.

Perhaps, for both the present and history, the subject of suffering and the value attached to it — in terms of doctrine and magisterium as well as the Pontiff's personal experience and testimony — constitutes one of the truest and deepest keys to interpreting his pontificate. The traditional descriptive definition seeing the Vicar of Christ as the *servus servorum Dei* might be completed, on being applied to John Paul II, as *servus infirmus servorum infirmorum Dei*. The Vicar of Christ, of Christ becoming Man and Redeemer of the world by taking on healing suffering.

At this historic Jagellons University, on the happy occasion of the granting of an Honorary Doctorate in Medicine, I have wanted not only the name — John Paul II — but constant reference to his doctrine, pastoral dynamism, and gifts as an expert on man and history and a leader inspired to implement the revolution of love in the world on the threshold of the third millenium to resound repeatedly.

May my oath of love and unconditional fidelity, decisively reaffirmed, go out to John Paul II, Bishop of Rome, Vicar of Christ, from the glorious Jagellons University, this noble Copernicus Academy. And for Poland, ever faithful, my desire for a time of peace and prosperity, with the help of God, by the mediation of the Most Blessed Virgin.

My heartiest best wishes to you, valiant Polish citizens!

[1] *Redemptor Hominis* 7
[2] *Ibid*. 10 14.
[3] *Salvifici Doloris*, 3
[4] *Ibid*., 19
[5] *Salvifici Doloris*, 25.
[6] *Laborem Exercens*, 27
[7] *Sollicitudo Rei Socialis*. 13-15
[8] *Christifideles Laici*, 38
[9] Motu Proprio *Dolentium Hominum*, 2
[10] *Salvifici Doloris*. 30
[11] *Redemptoris Mater*, 24
[12] *Salvifici Doloris*, 30.
[13] *Ibid*.
[14] *Laborem Exercens*, 19
[15] Motu Proprio *Dolentium Hominum*, 2.
[16] Synodus Episcoforum, *Instrumentum Laboris* (E Civitate Vaticana, 1990), nos 2, 3, 47.
[17] Congregation for the Doctrine of the Faith, *Instruction Concerning Respect for Human Life at Its Origin and the Dignity of Procreation*, 3
[18] Cfr. General Audience of April 27, 1980 and also "Allocution to Participants in the Fifteenth World Congress of Catholic Physicians," October 5, 1982.
[19] Cf. *L'Osservatore Romano*, November 17, 1989.
[20] "Allocution to Participants in the Fifteenth World Congress. . ." no 6.
[21] *Ibid*., no 6.
[22] Cf *L'Osservatore Romano* Weekly Edition June 16-23, 1983, p. XXI.
[23] Motu Proprio *Dolentium Hominum* 6

The Future Kingdom Is in Our Midst

The closing reflection, conclusions, hopes, and values examined at the Fourteenth World Congress of CICIAMS, held in New York, June 10-15, 1990

It is possible to announce the conclusion of a Congress we have experienced together? Each one of us, every Association, every country has pointed out specific convictions, questions, and hopes. The New York nurses gave us a warm welcome and enabled our sessions to be held in a satisfactory way at Mount Saint-Vincent — we shall long remember their outdoor evening barbecues.

Beyond this pleasant sharing, the Fourtheenth World Congress sought

— to manifest the impact of rapid cultural and social change on conceptions of life, death, health/illness, aging, etc.;

— to make health professionals aware of the decay in values guiding their professional practice — hence the urgency of making the Gospel principles present and operative in the living tissue of cultures and the environment, as also applies at all levels to policy-making structures, health programs, and medical facilities.

It is the duty of every participant, of every national Association, to draw up a balance and state whether this Congress has achieved its goals (see the evaluation sheet).

"Health Care and Values in a World in Transformation" was the subject dealt with in the initial address by Sr. Rosemary Donley, and the closing statement was prepared by Archbishop Angelini.

We may affirm that many speakers of outstanding caliber authoritarively set forth the main dimensions of the *values* on which nurses and midwives can base their participation in promoting "health for all by the year 2000."

Human, spiritual, and Christian values in our societies have been marked by deep and swift sociocultural change.

It is a matter of calling for ethical discernment, a perspective opening the way for the integral development of man and humanity. In the near future, what will child care and other forms of health care be like? Will we all manage to devote ourselves as Catholic health professionals to values which are the basis for our practice and act concretely in this evolving world to introduce therein "goodness, truth, and beauty," values concerning which Fr. A. Rust Crollius spoke to us?

But what modes can best respond today to the demands of the adequate practice of our social and health profession? We particulary stress the need to prompt:

— education, solid, open training, real competence;

— collaboration, agreement among professionals and other partners, a multidisciplinary team;

— development of a real relationship with patients, families, communities, in respect for truth and freedom;

— greater weight for Catholic professional associations in their role and significance.

These are the aspects taken into consideration and dealt with by speakers at the four sessions.

All of these contributions and others which we cannot comment on here opened up broader horizons for us and numerous fields.

What orientations did the conclusion of this Foruteenth World Congress invite us to adopt in the next four years?

The next world assembly — the fifteenth — will be visibly placed at the half-way point of the final decade of the twentieth century, the bearer of the third millenium (cf. J. ATTALI, *Lignes d'horizon*, 1989), charged with human challenges for society and the Church.

What place will our Catholic professional associations and CICIAMS occupy, what role will they represent during this crucial decade? It is up to us to decide and act in such a way that

— our associations will be a force of support and cohesion for Christian health professionals, in the face of the general devastation of traditional values;

— CICIAMS will be a meeting-place for Catholic professional associations and a competent, credible interlocutor before the sectors orienting government and world decisions.

I. Associations, a Force of Support and Cohesion for Christian Health Professionals

"Nursing personnel cannot act alone — midwives even less so — or practice under their own responsibility in the professional field" (Ethical Ref. 5.5). We bear in mind the suffering of those caring for the sick. Today hitherto unknown situations and equally unparalleled responsibilities are encountered. Let us recall the vast area of the consequences projected for the possible application of biomedical techniques, which man no doubt already masters, but which may lead to disastrous results for the future of the human race.

Let us also recall environmental decay in ecological imbalance due to an imprudent abuse of resources, which may take man to the brink of self-destruction (John Paul II, January 10, 1990, No. 7).

At the same time, the Council for Justice and Peace, in a document entitled *The Church Faced with Racism*, recalled that "law quickly establishes insurmountable barriers so that these techniques will not fall into the hands of abusive and irresponsible powers which would seek to 'produce' human beings selected according to criteria of race or other particularities of whatever kind..." (in *Ciciams Nouv.* 1/89).

"Produce" is not a neutral verb. The new form of the market order we have entered can transform everything into merchandise: nature, the natural resources of poor countries, lost-cost labor, and man, health, and life regarded as objects — all of this subjected to the weight of money, economics.

With great effort we have perceived the extent to which care is found to be wretched where technology dominates. "Lady Care" is sick alongside the road, and Sr. Juchli invited us to join with others wishing to act and find united paths and strategies which may put "Lady Care" back on her feet.

But solicitations to think differently are numberless and insistent. With every new technique, the mass media intone a hymn to science, inciting the population to believe that a better future is approaching, a mythical future in which suffering and death will be defeated. The mass media themselves become the bearers of false values of the market and money, of sex, of materialisms of every kind introducing ambiguites and contradictions into the world: disdain for life (abortion, euthanasia, etc.) and social violence in all its forms (attempts on lives, drugs, the elimination of ethnic groups, etc.).

For this reason professional organizations must be a supportive pole, a center for reflection and continuing education where members learn to

— *analyze* social and biomedical facts and the changes they produce;

— *enlighten their judgment* to demand responses to the different pressures, in a decision-making process (Sawicki);

— *make the competent authorities aware* of the thought of the professional body;

— *organize*, when it becomes necessary, opposition to laws contrary to the best interests of the population needing care and of professionals themselves.

When these professionals are Christians, they also have the right and the duty to demand spiritual and doctrinal clarity and a rebirth of their faith from their professional association so that it may venture to speak with relevance on behalf of aware Christians.

Offering room for thought and identification, our associations of health professionals can enable members to

— conduct mature reflection on human, social, cultural, and ethical challenges;

— have available precise data and affiliations in both professional and Christian terms (*T.R.* 4, M. Lacage).

II. CICIAMS: A Meeting Place for Catholic Professional Organizations

Acting as a support for professionals around the world in its proper sphere, CICIAMS is a place for cohesion and agreement. Its future is inscribed in that of the planet. The sixty CICIAMS member organizations embrace the world's horizons — those areas which are dominant as well as those growing ever poorer. We have seen that in many countries today poverty often forces whole populations to sacrifice two of the essential pillars for their development: health services and education.

In this context we have something to say and to do as agents of respect for the right of all to health, when so many million people in all countries cannot attain this — including countries like the United States, as the words of Pamela Maraldo and many others who have spoken at the assembly have shown us.

The complexity of our world calls us to a

clear-cut identity *and* solidarity among Christian professionals in every professional association and among associations on a worldwide level.

CICIAMS offers this point of confluence and has the vocation of cultivating solidarity among peoples, in the field of care by nurses and midwives, which is its specific terrain — a solidarity manifest at a world congress such as this one in New York (Joblin, C.N. 1/90, p. 2).

To introduce the values of truth, justice, and solidarity in accordance with the Gospel into our daily actions, to bear witness to the fact that Christian morality is possible and make man more human (Joblin) — this is what CICIAMS invites us to do.

We are faced by ethical challenges on a worldwide scale, such as

— individualism and the reappearance of national particularisms;

— the multiplication of the excluded and marginalized, who flee to drugs, alcohol, and nomadism in search of a dreamland, a paradisiacal world, while, however, destroying their health;

— the rapid spread of AIDS, with its serious repercussions of a moral, social, and economic nature affecting all individuals, families, communities, and nations (*C.N.*, p. 19). The session chaired by Monsignor Cassidy illustrated this point for us.

" The existence of Christian organizations becomes necessary in this world where solutions to problems need the consultation and agreement of all " (*Ref Eth.* 5.6).

This agreement goes beyond simple associations of health professionals: there are few institutions or organisms which, under one aspect or another (architects, city planners, environmentalists, etc.), have not taken an interest in improving health. " The interdependence of the numerous challenges the present world must take up confirms the need for agreed-upon solutions based on a moral, consistent vision of the world " (John Paul II, 1/1/90). Pamela Maraldo stressed this very idea.

All — particularly health professionals, who devote themselves to diseases, which directly affect life, suffering, the deaths of men, women, and children in our time — are duty-bound to participate in the creation or recreation of a humanity willed by God in his image and likeness.

Will we succeed in building together a vast " society of those responsible for care " on a world scale to take on the valiant risk of creating a network for exchanges to foster the " culture of Love " (Rust Crollius).

III. CICIAMS: Competent and Credible Interlocutor of International Institutions

One of CICIAMS's original points consists of being at once an NGO (Nongovernmental Organization) and a CIO (Catholic International Organization). With this twofold title, its vocation involves being an interlocutor of international institutions, places where decisions affecting mankind are oriented. Our visit to the UN on Tuesday, June 12 made us aware of this, and we are grateful to the New Yorkers for having given us that opportunity.

The consultative statute of CICIAMS gives it access to WHO, BIT, FISE, UNRRA, UNESCO, UNICEF (contacted during this congress).

Its being recognized by the Church enables it to establish a dialogue with all the

other CIO's within the CIO Conference. Recognition from within and without as a "Church community" has turned into a symbol.

The Congress, in its varied contributions, has developed the foundations upon which we can support solid convictions relating to our conception of life, health, disease, old age, and death. It has allowed us to reinforce our faith in the human being in all his dimensions, the very center of care, and our faith in humanity going towards the unity of the Kingdom.

We clearly realize that all of this intersects with the topics and questions dealt with by the international organizations with which CICIAMS works:

— the role of health policy and development;

— fostering peace among peoples;

— respect for the environment and its influence on health;

— primary health care and community health;

— training of health personnel, including instructions on human rights;

— role of the family;

— children, the wealth of the world (FISE);

— refugees and the problems of immigration (UNRRA);

— culture (UNESCO's concern for this decade; cf. C. Nouvelles, issues in recent years).

But under what conditions will CICIAMS be understood in these different bodies? What *breaches* can it make? L. Fiori insisted on this point at different times (*T.R.* 4).

To be an "understood" interlocutor means to possess real competence which is unceasingly updated, with credible, mature language, as we have stated, in our national associations, which continually spreads by way of association.

Recognized as contributing concerns and legitimate interests, our associations — which are by nature embodied in practices relating to human existence — are called to play a primary role in the structure of places and organizations influencing policy, economics, and social relations. In the framework of CICIAMS, grouping together our associations internationally, they can express their ideas on the highest level — the values and convictions animating their health activity and their reflections on the explosive questions arising nowadays — and also propose possible solutions.

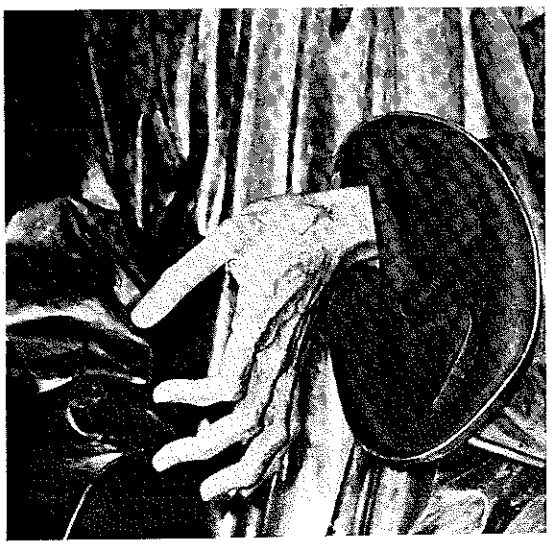
When ethical problems are considered, can our words as Christians be heard and taken into account by the "speakers," those with power to proclaim laws and impose them on national populations that are more or less manipulated in the direction willed by politicians, and by those who, internationally, follow more complicated and subtle roads, using powerful economic and communications levers?

Will we be interlocutors that are heard and recognized if we are not represented by solid, strong organizations? It is true that numbers count, but the seriousness of documents and their argumentation, based on real objectivity, rigorous methods, in-depth analysis of what is really at stake, and a judicious use of the scientific approach count more.

When it is a question of ethics, Catholic professionals are duty-bound to support their motivations on the basis of conscience and enlightened judgment, especially by consulting qualified people and Catholic orientations (*Ref. Eth.* 4.18).

Researchers and experts, including non-Christians, recognize the unicity of the human being, the concept of the end of his biological life, his exceptional destiny alongside other forms of life existing on the planet. Does our Christian faith no longer offer us more attractive grounds for defending life as an absolute value against all the forces of death?

Prompted to make its contribution to social debates on the leading health-related problems (arising from biogenetic discoveries, the breaking of the marriage and family bond, population manipulation,



and the concentration of great masses in the megalopolis), will CICIAMS be able to play its role as an active partner? It will if we manage to develop regular growth in *communication* between CICIAMS and national associations and if their members are convinced they must *contribute their share* to cause the Gospel-based values to prevail.

To think globally and act locally was the guiding principle of WHO's World Health Day, last April 7. Can we make it our own here? To act locally by means of our professions, our teams, our establishments, our associations, and inform concerning this whoever — man or woman — takes on responsibility for stimulating and representing CICIAMS internationally.

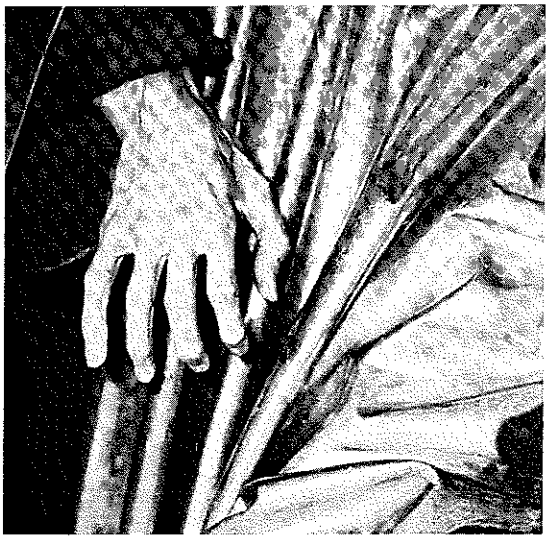
In the face of what we have heard and shared among ourselves, at least four roads have been opened during this Congress:

1) *The family* as the first social community. Health professionals have a mission to fulfill: to promote essential family values and propose action programs, with respect for every country's mentality and culture.

2) *The moral dimension of culture*: to develop access for all to a culture which will aggrandize the human being, when so many individuals and peoples are humiliated, reduced to situations of exclusion.

Culture is situated in an environment to which the relationship between man and the creation is joined. Should health personnel, in the name of respect for life, not pay attention to the integrity of creation?

CICIAMS and the organizations it represents have a special responsibility concerning these points as Catholic bodies.



3) The appropriate *training* of health personnel: to support research and specify the means to be applied are a prime necessity — training which shows that we can still get into a profession today because we *love to care for our fellow men*.

4) *Women*. Health professions are made up of women on a majority basis. Through and in their associations they manifest the contribution proper to women in building the Church and developing society, specifically fostering life in its fullness (Ref. in *J.P. II*). To put the values specific to them back into their rightful place — doesn't this mean participating in the advancement of women in different societies? We all know the extent to which woman's impact is fundamental in family life, cultural development, respect for the environment, and education.

Participants in this Fourteenth World Congress of CICIAMS, in a few days we shall be going back to encounter our daily surroundings. Enriched by all our international contacts, here we are, about to be sent back to build the world, our planet, to be actively present in the human city, with impassioned concern for *life* at the core of our professions as people charged with caring for our fellows.

We are all invited to walk together towards the horizon of the third millenium. Let us engage our energies as Christians to disseminate the values recalled during this assembly and advance in unity with one another so that "Church communion" will be achieved with respect for our cultural and racial differences.

We can thus offer the world the alternate utopia it lacks — *brotherhood* — to which John Paul II invites us in his message of January 1, 1990.

Brotherhood inhabited by the Love which gives itself when it is lived out in the exercise of our profession of caring for the sick. Brotherhood which, in a network of concrete solidarity among individuals and peoples, sends the world a message of hope: *The future Kingdom is in your midst*.

Sr. ANNICK LEROUX
France

Biological Nature and the Dignity of the Human Person

Seventeenth World Congress of FIAMC
Bonn, September 14-18, 1990

Some 400 doctors from 27 nations, representing thousands of physicians who profess themselves to be Cahtolics, met to listen, meditate, and discuss topics charged with ethical and, in addition, undoubted scientific content — prenatal diagnosis, experimentation on and use of embryos and fetuses, the manipulation of human identity, sexuality and its deviations, the artificial prolongation of human life, suicide and euthanasia, and death and brain death — over a three-day period.

Papers were presented by top-flight experts, though unfortunately not all manifested a clear-cut adherence to the Church Magisterium at every point.

Participants in the plenary sessions in the morning later met in language groups to work out their reflections and proposals.

The inaugural session opened with the reading of a message sent by the Secretary of State, Cardinal Agostino Casaroli, on behalf of the Holy Father, John Paul II.

FIAMC President T.P. Linehan, M.D. then read some reflections sent from Rome by Arcbishop F. Angelini, President of the Pontifical Council for Pastoral Assistance to Health Care Workers.

Fr. E. Schokenhoff, Ecclesiastical Advisor to the Catholic Medical Association of Germany, delivered the inaugural address on " The Dignity of the Human Person ":

" At the center of ethical reflection today stands the notion of the unrenounceable dignity of the human person. This is a concept accepted by all physicians, even those differing most from the standpoint of their interpretation of human nature, as a common starting point.

" Christians, like others belonging to different religions, in this concept find the expression of their own conviction concerning themselves from a religious point of view: human dignity represents the *leitmotif* of the political and juridical history of freedom in modern times....

" But in the notion of human dignity there are two components which are integrated, but which must be considered separately: the norm which prohibits sacrificing a person to objectives that are foreign to him, and the much broader notion including the guiding images of an anthropological project and the idea of a fulfilled life.

" The topic of human dignity remains formidable and imperative only in its restrictive, core sense: pluralistic society itself cannot afford to go beyond this frontier if it does not want to destroy the cultural reasons which have ' originated ' it. "

The first plenary session, devoted to " Ethical end Technical Questions Concerning the Beginning of Life, " included statements by three speakers: Senator Adriano Bompiani (Rome), who dealt with prenatal diagnosis with notable expertise and balance; Professor H.B. Wuermeling (Erlangen), who presented the delicate problematic of FIVET under the scientific and ethical aspects, showing some disagreement with the Church Magisterium set forth in *Donum Vitae* (thereby prompting extensive perplexity among numerous participants, particularly the Italian contingent); and, finally, Professor J. McLean (Leeds), who provided a judicious account of " Experimentation on Embryos and Fetuses. " Among other things, Professor McLean asserted, in keeping with the document *Donum Vitae, " IVF is an unacceptable method as a treatment for sterility ... In vitro* fertilization is a method used in many countries and by many researchers, who state that the very low 10% success rate with IVF (the percentage of live births) could improve only if experiments were carried out on human embryos. Further justifications have been invoked for this type of research, such as its presumed usefulness in diagnosing chromosome and genetic alternations and deformations in the period preceding nesting and in preparing new birth control methods.

The speaker went on to point out that the research on the human embryo approved by several countries accepted " destructive " experimentation with no therapeutic finality for a certain period after fertilization. This type of research is contrary to the traditional ethics of medicine, with its demand that the lives of all human subjects in research be medically protected.

Time limitations prevented Professor McLean from dwelling upon " alternative methods to overcome sterility and prevent some chromosome and genetic diseases which are consistent with thoroughgoing respect for human life. "

The second plenary session was devoted to " The Human Person: Man or Woman. " Professor A.W. Von Eiff (Bonn) spoke on " The Specificity of the Human Person as a Man or a Woman, " presenting phylogenetic development with great expertise and precisely describing the role of the brain in the development of the feminine or masculine personality.

Professor J.P. Luton (Paris) dealt with " The Biological Bases of Sexuality and Its Deviations, " stating that in the last thirty years better knowledge had been obtained of sexual differentiation, some organic pathologies have been specified better, and a better understanding has been reached of subjects manifesting sexual ambiguity. The diseases of gonadal agenesis and the sexual ambiguities provoked by hormonal hypersecretion (the best known of which is congenital hyperplasia of the adrenal glands, sometimes leading to a morphological aspect totally opposed to the genetic sex) were thus brought out.

Finally, Professor R.A. O'Connell (New York) read a report on " The Manipulation of Human Identity: Psychological and Social Factors Influencing Sexual Identity. "

The speaker specified that " sexual identity comprehends three aspects: feminine or masculine biological characteristics; sex identity, or the personal feeling of being a woman or a man; and sexual orientation, whether heterosexual, homosexual, or bisexual. " There are normally clear-cut anatomical and physiological characteristics of being a man or a woman and a heterosexual orientation. The stages of childhood and adolescence are particularly important.

The speaker went on to examine the influence of chromosome alterations as a cause of sexual modifications and the great importance of family and socioenvironmental factors (including the messages of the mass media) on the sexual orientation of the young.

The concluding session focused on the topic of " The End of Human Life. "

Professor J. Barreto (Porto) spoke quite lucidly on " Suicide and Euthanasia. "

In recent years some psychiatrists and researchers have tended to tolerate suicide ethically and juridically in situations of uncontrollable suffering, especially with incurable and terminal patients. It has been maintained that in such cases the action of taking one's life, sometimes with the help of doctors and others, is the result of a patient's free, rational view, provided he is not confused in his mental faculties as a result of illness and serious emotional disorders (rational suicide).

But we increasingly wonder whether " ration suicide " can really exist. Epidemiological surveys in fact show that there is a high percentage of psychiatric patients among those who attempt or carry out suicide. In any event, recent studies appear to have shown the existence of imbalances in the distribution of brain amines among those who actually commit suicide, independently of the degree of depression.

Professor Kwang-Ho Heng (Seoul) focused on " The Artificial Prolongation of Life, " referring to a survey of 250 nurses working in intensive therapy units at fifteen Catholic hospitals in Korea and analyzing their views on the topic at issue—i.e., resorting to life maintenance systems when brain function has irreversibly ceased.

The speaker forcefully recalled the Church's documents, from Pius XII's allocution to the statement on euthanasia by the Congregation for the Doctrine of the Faith approved by the Holy Father John Paul II in 1980, as well as the report by the Pontifical Academy of Sciences working group on the artificial prolongation of life

and the document on "determining the precise moment of death" published in 1985. The artificial prolongation of life, in any case, remains linked to the subject of "brain death and the methods used to diagnose it."

Finally, Professor C.J. Vas (Bombay) dealt precisely with the topic of "death and brain death."

The speaker, after reviewing the concept of death historically and philosophically up to the recognition that the brain is the organ of reference for this problematic, concluded that criteria for ascertaining a person's death must refer to brain death (not just the cortex, but also the trunk). The criteria of death for children under three months of age were more difficult, delicate, and precise.

The content of the Seventeenth World Congress of Catholic Physicians fell into three general categories — scientific, technical, and ethical — with frequent reference to the documents of the Magisterium, as ought to be the case with doctors drawing inspiration from the Gospel message. The medical profession cannot, in fact, be regarded as such if it is not understood as a service to the human person — the doctor cannot limit himself to treating the suffering body alone, but must extend his technical capacity to the whole person, body and soul.

Technical progress, which is virtually explosive, is positive if it is aimed at helping man; but a real danger exists of deviation towards irrational "pseudoachievements," with serious disturbance of consciences and of balances attained with great effort.

If men of science and researchers lack the humility to pause at least for an instant to evaluate their "creative" potentialities, anguish and indignation could divide men into irreconcilable factions.

If the lack of behavioral ethics in society, in the organisms charged with guiding peoples, and in families does not make a vigorous about-face, what society will we be capable of contructing for the young people of the next century?

As Catholic physicians from all over the world, we well know these problems and these dangers, for we are responsible citizens dedicated to this society. But our ethical formation, our humanistic culture illuminated and guided by the light of the Faith, must constitute the necessary force to contribute to building a better world.

Indeed, what would be the use of openly declaring ourselves to be Catholics, what would it signify to be recognized as Associations at the service of the Church Magisterium, and what value would our National and International Congresses have if we were not clearly convinced that, in addition to just *being* Catholics, we *are able to act* as such?

FIAMC, through its presence on the five continents, must be capable of spreading this spirit of witness among its members, particularly in a field like that of suffering and health, where profession is inseparable from vocation.

DOMENICO DI VIRGILIO, M.D.
President of the Catholic Medical Association of Italy

Catholic Pharmacists

Celebration of the Fortieth Anniversary of the International Federation, Rome, November 3-4, 1990

The International Federation of Catholic Pharmacists appeared on September 2, 1950. Pius XII consecrated its activity with a memorable address. The first National Union had arisen in Belgium in 1945, through the initiative of a pharmacist-priest. In Italy it was founded by Pietro Olivieri, a pharmacist of the Ligurian countryside, in 1947.

Forty years later, November 3, 1990, to be exact, 300 pharmacists recalled the origins of FIPC at a meeting in Rome. The Pope delivered an address on this occasion as well which was incisive, direct, and clear. John Paul II spoke to the International Federation of Catholic Pharmacists to ask them to abide by a "rigorous moral code" and follow the indications of the Church regarding the distribution of medicines that might be used against life "directly or indirectly."

The Pontiff's invitation to carry out forms of conscientious objection with respect to products such as the Ru-486 abortion pill or substances which can facilitate euthanasia, though not made explicitly, is evident from the talk delivered to the international delegation of pharmacists received in an audience at the Vatican.

John Paul II said, "In distributing medicines, the pharmacist cannot renounce the demands of his conscience in the name of iron laws of the market or complacent legislation. Earnings, while legitimate and necessary, must always be subordinated to respect for the moral law and adherence to the Magisterium of the Church." "For the Catholic pharmacist," he continued, "the Church's teaching on respect for life and the dignity of the human person, from the moment of his conception until his final instants, is of an ethical and moral nature. It cannot depend on changeable opinions or be applied according to shifting options."

The Pope recalled that the Church, "aware of the novelty and complexity of the problems posed by the progress of science and technology, makes its voice resound more and more frequently and gives clear indications to health personnel, of which pharmacists form part. To offer one's own adherence to these teachings surely represents a difficult duty to respect in the concreteness of your daily work, but for the Catholic pharmacist it is a question of fundamental orientations he cannot renounce."

The address of course made a deep impact on those attending, as reflected in remarks by Archbishop Angelini, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, the FIPC's Ecclesiastical Assistant, Abbé Schaller, and the Federation President, Magister Edwin Scheer.

Archbishop Angelini, in a talk in the course of the meeting, spoke of the pharmacists' profession as a mission requiring the courage to swim against the stream: "It is a profession of great nobility and cannot be reduced to mere commercial activity. But the foundation for this mission is union with God and deep respect for the person and human life. The Church is not against progress, but always intervenes in defense of man in the face of an indiscriminate, selfish freedom that does not stop even at the destruction of human life. But the pharmacist's profession is also great, for it acts as a mediator between science and the public. Behind his counter, the pharmacist is a faithful friend and counsellor." In this regard, Archbishop Angelini recalled a painting of the eighteenth century, exhibited in Vienna's Osterreichisches Museum, which depicts Christ himself distributing medicines from behind the pharmacy counter.

In his words of greeting for foreign colleagues, the President of the Italian Union, Lino Mottironi, stated at the beginning of the session:

"This gathering together in Rome aims, above all, at being a witness to faith. The faith in Jesus Christ which must nourish the exercise of the pharmacist's profession. But it also aims at being the expression of the significance of professional associations in the Church: a way of being the Church, a way of living out as lay people the Church's mission. The new evangelization needs all believers and, therefore, the Catholic pharmacist as well — a man, a professional to whom many suffering people or relatives of those who suffer turn confidently each day.

Pope John Paul II, in the Motu Proprio by which he instituted the Pontifical Coun-

cil for Pastoral Assistance to Health Care Workers in 1985, called us to this friendly and solidary closeness.

Evangelization, for our Catholic pharmacists, begins precisely with our contact with the public, with the way we manage to establish a relationship, with delicacy and humanity. It will be a very brief relationship, but it must leave a sign. A sign of love God reserves for each soul. We mean this when we speak of "humanization" of the profession. And we are sure that this way of treating pained and anguished human beings with respect and tenderness is the first medicine — and perhaps the best one — with social consequences of a scope which we cannot even imagine.

Another profound conviction, arising from God's love for man, is that, like every other health profession, ours is always at the service of life. As believers in the Living God, we are always on the side of life. We shall never adapt to becoming dispensers of death. "I shall hold man responsible for man's life and each one for his brother." These words of the Lord, which we read in Genesis, are the basis for our professional ethic.

What route has been followed by the International Federation over these past forty years, and what will its future be? As regards the past, it was the founder himself, the Belgian Parat, who recalled the circumstances in which the FIPC arose. The Honorary President — and President of the FIPC until September 1987 — covered the cultural itinerary and the ethical and professional achievements by way of the history of the nineteen international congresses. The specificity of the profession, its role in civil society and in the health community, and, at the same time, its liberal character were the fundamental topics of the first congresses. But the pharmacist's identity reached a crisis in the 1960s. And in the seventies, with large-scale social change and technological progress, pressure on the pharmacist — applied by two forces crushing his profession as if in a vise — became stronger. On the one hand, there was an increase in ready-made industrial products requiring only commercial distribution by the pharmacist; on the other, there was a growing bureaucratization of the public healthcare system. These forces seriously endangered the independence, the responsibilty, and the scientific culture itself of the pharmacist.

Like all the other associations at that time, the FIPC went through a crisis. But at the Graz Congress in 1983 four points were formulated which were regarded as fundamental and constituting an identity which had not been lost, but had been rendered a bit confused by historic changes. The pharmacist's profession in these new times is based on competence, which clearly distinguishes the pharmacy from a supermarket; responsibility, which makes the pharmacist an indispensable link in the doctor-patient relationship; and freedom, which distinguishes a serious professional from a civil servant. The profession was requalified on the basis of these points. The figure of a competent professional and scientific counsellor with the mission of contributing to he health education of the public with whom he entered into contact every day was once again proposed to society. In addition, the pharmacist claimed the freedom of conscience which would allow him to provide Christian witness in those instances where nascent (or terminal) human life was at stake. These four pilasters remain fundamental in the nineties. But "the future is ahead and burns in our hearts," FIPC President E. Scheer stated in his talk. And there is no lack of new problems in professional ethics which present difficulties for pharmacists. And other problems are posed for Christians and Christian professionals — for instance, hunger in the world and the aid Western Europe must give to the Eastern countries, humiliated and exhausted by Communist regimes. These are challenges we have to accept, Scheer said, by increasing our religious formation, which helps us to live through the ethical tension which the health professions must experience.

Some of the outlines of such formation have been traced by the administrator of the Italian Union, G. Fattori, who spoke of the conversion making all things new and giving them all new meaning. In deepening and maturing its religious faith, the profession itself can come to be a source of evangelization and service to the poor and sick. This is the only guarantee saving the profession from turning into a mere business.

Dr. GIOVANNI FALLANI

Magisterium of the Church

Excerpts from addresses by the Holy Father

Do Not Fear Having Children

(On April 28 the Holy Father received in audience participants in a Family Ministry convention sponsored by the Italian Bishops' Conference)

Your convention has the goal of reflecting on the great and fundamental contribution which the family is called to make towards effectively serving life. For is the family not the natural place in which human life is born, grows up, matures and declines? *Therefore it is the family's task to place itself at the service of every life and of all life, even when life presents difficult moments and problem-filled aspects. What's more, it is right to expect that especially in such circumstances the family will find a way to express* that quality of concern and tender affection *which characterizes the specific spiritual texture of its life as a community of love.*

Especially if the family is established on a healthy base, it will find the way to accept children generously *as a concrete sign of its love of life and as a clear witness of its trust in divine Providence, which never abandons those who entrust themselves to it with active serenity. This goes especially for young families, which if they are trained in a Christian spirit, will not let themselves be conquered by an unjustified fear of having children and will find a way to overcome the many groundless and selfish tendencies towards putting off giving birth, aware as they are that "children are the supreme good of marriage"* (Gaudium et Spes, *n. 50) and the sign of blessing from the Lord, the "lover of life"* (Wis *11:21).*

This becomes especially important at a time of a sharp demographic decline such as we are experiencing in Italy. Families must once again express a generous love for life *and place themselves at its service above all by accepting the children which the Lord wants to give them with a sense of responsibility not detached from peaceful trust. It is this attitude which, if it is taken on with consistency, will allow families to be open to accepting even the numerous situations of physical and spiritual difficulties which life can offer as time passes and will dispose them to offer solidarity and concrete help to so many people presented to us by society who are marginalized, infirm and elderly.*

The Church Finds in Your Pain, Offered to God in Union with the Passion of Christ, Strong Support to Carry Out the Mission the Lord Has Entrusted to Her

(To the sick at the Villahermosa Cathedral, Mexico, on Friday, May 11, 1990)

I now wish to address the sick present here and all who suffer on account of illness in the Mexican Republic. I address all of you who suffer to tell you once again that you truly occupy a privileged place in the heart of the Church, in the Pope's heart: the Pope, just like the whole Church, finds in your pain, offered to God in union with the Passion of Christ, strong support to carry out the mission the Lord has entrusted to her.

If all of us Christians form the Church of Jesus Christ as living stones, you, the sick, are in a certain sense the foundation for this edifice. Christ, who has died and risen again, is the foundation, the cornerstone, and together with Him, giving solidity to the building, occupying an apparently hidden and unknown place, are you, when you join your pain to the salvific pain of the Redeemer.

The Gospel has transmitted to us numerous examples of Jesus' attitude towards the sick: the blind man begging on the street (cf. Mk *10:46 seq.), the woman suffering from a haemorrhage (cf.* Lk *8:40 seq.), the man with a paralyzed hand (cf.* Mt *12:9 seq.), the crippled woman (cf.* Lk *17:12 seq.), and the lepers (cf.* Lk *17:12 seq.). Many are those who approach Jesus on account of their illnesses: perhaps they would not have approached Him if they had been healthy.*

Brothers and sisters, dear sick people, you know, you have had this experience: illness, when accepted, draws us near Christ.

*Illness sometimes causes man to fall from his pedestal of arrogance and discover himself to be what he really is: poor, invalid, needing the help of God. Illness frequently leads to radical changes in the relations between God and a person. "Courage, my son; your sins are forgiven" (*Mt *9:2) are the first words the paralytic from Capernaum hears; "Now you are well again, do not sin any more, or something worse may happen to you" (*Jn *5:14) is what the Lord says to the paralytic at the Bethesda Pool. There are numerous miracles performed by the Lord on the bodies of these patients, but multiple and more important are the ones He works in their souls.*

*These healings are used by Christ to announce the coming of the Kingdom. "Go and tell John what you hear and see: the blind recover their sight, the lame walk, lepers are cured, the deaf can hear again, the dead return to life, and the good news is preached to the poor" (*Mt *11:4-6). The sick in the Gospel are a sign of the Kingdom when they are healed; you, too, are a sign of the Kingdom, and in an even greater measure, when, in accepting the will of God, you live through your illness with joy.*

Do you understand why the Church looks at you with predilection? Do you understand why the Church relies on you in a special way? Do you understand why the Pope asks you for the treasure of your pain to carry out the new evangelization of Tabasco, of the Mexican Republic, of the whole world? In your sick bodies, in your suffering, in your weakness, and, above all, in your joy, where you are, joined to Christ, the Church will find the strength to spread the work of evangelization which He Himself has entrusted to her.

Before concluding, I wish to manifest my deep appreciation to those in hospitals, sanatoriums, care centers, and Mexican families devote their professional capacity and their solicitude to relieving and looking after their suffering brothers and sisters.

I entrust you patients present here and those witnessing this encounter on radio and television to the motherly care of Our Lady of Guadalupe, while I affectionately bestow a special Apostolic Blessing upon you.

Suffering Helps Others

(Meeting with the Sick in Rabat on May 27, 1990)

Dear Brothers and Sisters in Christ,

1. The sick are a very special part of Christ's Body, the Church. This morning I am pleased to meet some representatives *of the people in Malta and Gozo who are* elderly or suffering from various forms of illness. *In greeting you, I make my own the beautiful words which we find in the First Letter of Peter: "Rejoice insofar as you share Christ's sufferings, that you may also rejoice and be glad when his glory is revealed" (*1 Pt *4:13). Let us indeed praise Almighty God for the many ways in which he strengthens us in hope and gives us his consolation, even amid the trials and sufferings that accompany our life here on earth.*

*The Church's concern for the sick derives from the example of Jesus himself, who in preaching the Gospel of the Kingdom went about "healing every disease and every infirmity among the people" (*Mt *4:23). By his many miracles, Jesus showed how close God is to each of us, and how great is his power to bring healing and salvation to those who call upon him in faith. In every age, the Church seeks to carry on Christ's saving mission by caring for the physical and spiritual needs of the infirm. She knows that God's grace is made perfect in weakness, and that in her suffering*

members the saving power, of Christ's Cross is mysteriously present and effective.

2. Not far from us is the Grotto where, *according to a venerable popular tradition,* Saint Paul lived during his stay in Malta. *As you know, Saint Paul rejoiced in the many sufferings he endured for the Gospel. He understood that* only by suffering with Christ *do we come to share in the power of his Resurrection (cf.* Phil *3:10-11).*

Our Catholic faith teaches that in the communion of saints the members of the Church are united with each other in a profound spiritual solidarity. Our prayers, our sufferings and our joys affect others in ways that are known fully to God alone. *Through the life of grace, each of us is given an opportunity to cooperate with Jesus in bringing the saving power of his Cross to bear on the needs of our brothers and sisters. As Paul himself put it, we can "complete what is lacking in Christ's afflictions for the sake of his Body, ... the Church"* (Col *1:24).*

When people are sick, or burdened by troubles, they are often tempted to think only of their own problems. But faith invites us to look deeper and to see the immense good that we can do for our neighbour by offering our sufferings in union with Jesus as a pleasing sacrifice to God our Father for the needs of all mankind. How many people today stand in need of our prayers! Whether we pray for our family or our friends, for peace among nations or harmony between individuals, for an end to problems such as hunger, disease, and drug abuse, we can be confident that our prayers will be heard.

3. Dear Friends: on this occasion I wish to say a special word of thanks to the individuals and groups who minister to the elderly and infirm in Malta. *Together with Government agencies, Church organizations such as the Kummissjoni Morda of Maltese Catholic Action, Caritas and the Association for the Transport of the Sick to Lourdes are dedicated to assisting Malta's sick. In her homes for the elderly, the handicapped, and those recovering from drug addiction the Church is making a notable contribution to the spiritual and physical well-being of Maltese society.*

My thoughts also turn to those many family members, friends and volunteers *who comfort and support the elderly and sick by their presence and love. Your generosity and compassion for your brothers and sisters in need reflect the image of the Good Samaritan (cf.* Lk *10:30-37), whose compassion for his neighbour was the expression of a profound love and solidarity (cf.* Salvifici Doloris, *28).*

In a moment we shall recite together the beautiful hymn: *"Regina Caeli," which invites the entire Church to share in the joy of the Blessed Virgin Mary at the Resurrection of Jesus her Son. Even when she stood at the foot of his Cross, Mary never ceased to trust that God's promises would be fulfilled. For this reason, Mary is the model of all disciples as they seek to follow the Lord in unwavering faith, hope and love. With great confidence in God's infinite mercy and goodness, then, let us join Mary on this last Sunday in May, Mary's month, in praying for all who bear a heavy burden of suffering that they may come to know the joy of his eternal victory.*

Mary: Pro-Life Symbol

After visiting the Blessed Sacrament and venerating the image of Our Lady of Graces at her shrine in Benevento (July 2), Pope John Paul II gave the following reflection:

Dear Brothers and Sisters,

1. In this shrine of Our Lady of Graces, the principal Patroness of Benevento and Sannio, I want to thank the Most Holy Virgin for this joy which is granted me to pray with you for the good of the City and the entire Region.

Before this miraculous image *multitudes of people from Benevento have come to turn over their sorrows to the Mother of the Redeemer and implore her help and protection especially during the terrible periods of the wars, the earthquakes and plagues, and especially during the bombing of the last world war, which destroyed a large part of the old city. Within the shrine, which itself was reborn out of the ruins of war, many have found comfort and courage. Here have come the rich and poor, the humble and the powerful, the well-educated and the illiterate.*

How many, tortured by doubt, have rediscovered here the light of faith! How many, oppressed by the anguish of sin, have experienced the unspeakable joy of pardon and reconciliation!

That is why this shrine has become a pole of attraction for all the faithful of this Region, in which Marian piety is so deeply rooted.

Dearest people of Benevento! Follow the steps of the pilgrims who have rediscovered the reasons lying at the root of their faith and their own lives, in this place before the revered image of Our Lady of Graces; keep that sense of unity, with this shrine as its centre, especially on July 2, the day when the Sannio area celebrates her Patroness in solemn fashion.

With loving intuition from ancient times you have been able to grasp the mystery of Mary, as mediatrix of all grace, because she is the Mother of the very Author of Grace, *Jesus Christ. That is why the people of Benevento throughout the ages have turned and continue to turn to her, invoking her not only as "Our Lady* of Graces, *" but often also as "Our Lady* of Grace. *"*

2. Dearest ones, the pilgrimages and visits which you make to this shrine should confirm you in this devotion you have to the Virgin, from it you are learning above all to believe *in the love of God the Father, in the power of Christ the Redeemer and in the transforming force of the Holy Spirit, which Mary welcomed without reservation.*

The Virgin teaches you besides to give your hearts to others, *as she did in the house of Elizabeth and in the home of the young spouses at Cana. Blessed will you be if you strive in Mary's school to learn to* praise the Lord in all circumstances, to proclaim His mercy, *to recognize the* power of His arm, *which scatters the proud, but exalts the lowly and fills them with good things (cf.* Lk *1:46ff).*

Blessed will you be as well if you are able to make room for human life about to be born, for persons which society rejects or excludes, for those who suffer in body or spirit, for those who have forgotten their own human dignity. The image of Our Lady, who holds the Child close to her breast, invites us to respect the human person, made in the image of God, and to defend it from birth until natural death.

3. O Mary Most Holy, "full of grace," help this people of Benevento who have recourse to you with your vigilant protection. Comfort the priests and the religious who are called to bring the message of salvation to modern society! Aid Christian communities and obtain for them the gift of numerous and holy vocations to the priesthood and religious life. Protect those who are entrusted with civil, social, and political duties so that they may always have as their goal the common good and the integral development of every man and woman.

Watch over all the pilgrims who revere you in this shrine, and the places where they live and work; bless the families of emigrants, the unemployed, the sick and those who bear in their souls the still-bleeding wounds inflicted during sad episodes of violence.

O Mother of Grace, protect all and grant that all may understand that the secret to happiness lies in kindness, mercy, and pardon. Amen.

What Would Pain Be without Christ's Cross?

During his July 2 visit to Benevento, Pope John Paul II visited with the sick and with doctors and nurses who care for them. The meeting took place in the gymnasium of the new Archdiocesan Seminary, which the Pontiff had blessed earlier.

1. I thank the Lord heartily for this meeting with you, dear patients and doctors, and I greet you from the depths of my heart, with special thanks to the person who expressed the sentiments of you all.

During pastoral visits, this appointment with suffering and with those who seek to conquer it and to alleviate it constitutes not only a duty for me, but also an occasion of

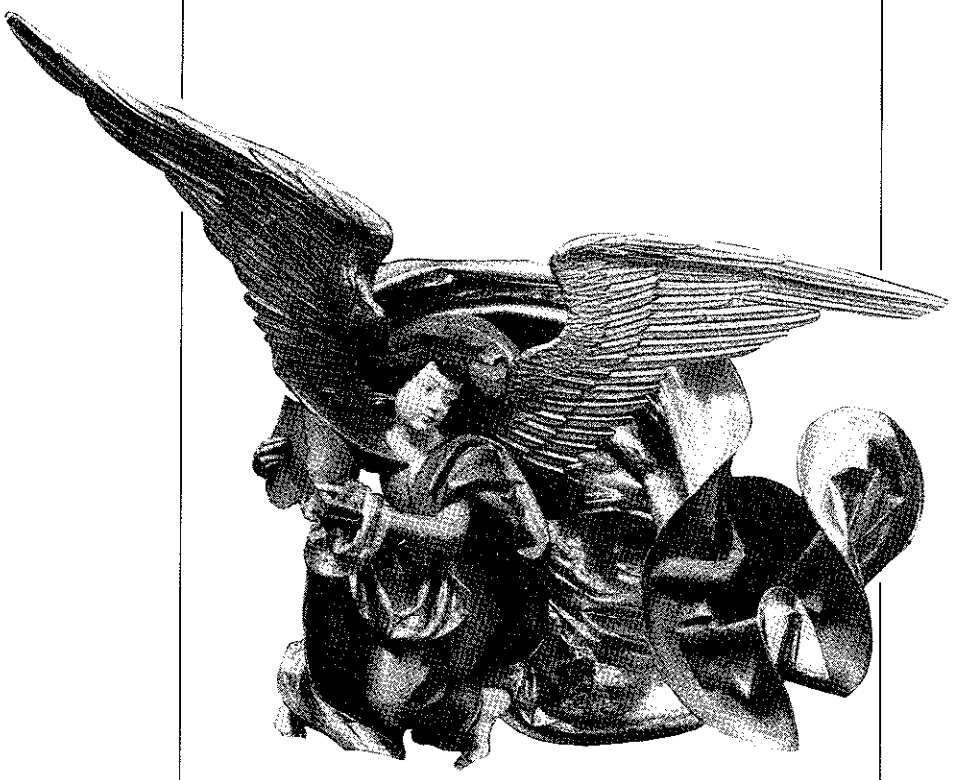
inner comfort. Dearest ones, I am here with you above all to share your hope. As is obvious on the human level, each of you carries within himself or herself the deep hope that you will win the battle against suffering and conquer the pain and humiliation of being sick. The Church is well aware of this feeling; in her prayer for the sick she constantly asks God: "Make manifest in the lives of our sick brothers and sisters the healing power of your Spirit, so that they may return quickly to the community of the Church to sing your praises" (cf. Roman Missal, Prayer after Communion from the Mass for the Sick).

This is my prayer today for you, too, dear sick people and I habitually offer this prayer for all those who are visited by illness. I feel especially close to them because I know well that Christ took the Cross upon himself, thus revealing the mysterious value of suffering and the redeeming power of sacrifice. In that way He assumed into His work of salvation the aspect of suffering which exists in every person's life, proclaiming that in all types of pain one can find a ministry of grace and blessing.

2. I extend a word of thanks to you, too, dearest doctors and nurses; you have chosen as a profession the service of the suffering, with the intention of relieving their pain and promoting their healing with constant care and generous dedication. Medical science is called to cooperate with God in defence of life and of the basic rights of the person who is suffering. The great doctor, Giuseppe Moscati, the glory of this land of yours, understood that well. By the light of his example, be committed sincerely and humbly to making real the moral principles which the Gospel proposes to you, taking your inspiration from Christ and his witness of love in decisions connected with your profession as health care workers and as guarantors of the true good of every person who is entrusted to your care.

This meeting has been full of very profound content. One's thoughts cannot fail to go to the Cross of Christ, of Christ Crucified. What would the world be, what would humanity be, without this Cross and without the Crucified One? What would human suffering be without the Cross and the Crucified? I would like to offer all of you a Blessing and a word of thanks for this meeting.

Topics



Migration Medicine
Medical Ethics

Migration Medicine: A New Challenge for the Health Apostolate

Introduction

The military physician Johannes Hofer maintained in a paper that a " strange ailment " was affecting lansquenet mercenary soldiers in a foreign land.

The fact that this affection — which was, moreover, insidious — spread more widely among the troops the longer they remained far away from the valleys of the Swiss Alps did not escape the brilliant doctor. He described the characteristic syndrome as follows: " a serious feeling of exhaustion, manifest depression, and a marked tendency towards indifference and unresponsiveness to orders. " He also stated that this set of symptoms was accompanied by individuals' continual requests to return to their homeland and that it became more evident after the soldiers gathered in the evening around the bivouacs to sing Alpine songs and joke, as was their custom. Dr. Hofer concluded his dissertation in the usual fashion, coining a term to enrich the taxonomy of the time: *nostalgia*, meaning ' homesickness '.

Nearly five centuries ago, then, a special terminology arose for a special kind of medicine which, unlike other branches, instead of digging trenches within classical nosology, was already aiming at far-sighted syntheses and interdisciplinary relations Down to the present day migration medicine has maintained intact its specificity as a distinct operative field sui generis as regards strategies for health action and programing, while at the same time being comprehensive with respect to its approach to man, no longer considered as simply *patiens*, in a strictly physicist view, but *homo dolens*, for whom suffering does not have bodily roots alone, but is dramatically permeated by the whole anthropology of the individual, in relation to the devil, death, fear, the witchdoctor, the sorceror, and the physician.

Ethnological reflection, psychological sensitivity, and complete respect and openness are thus indispensable for those working in migration medicine In this period of hypermedicalization, in which the figure of the integral physician is becoming increasingly obscured, apparently reduced to the status of a specialized technical agent, migration medicine con propose once more, with renewed vigor, the subject of the medical vocation and the mission of practice, with a fresh image of the physician of man and his history, of his earth and its people — an extremely demanding type of expression cutting across the common cultural baggage furnished by universities and drawing deeply from the spirit of each person in search of the most profound human, ethical, and religious motivations.

To facilitate our inquiry we shall list the basic points around which the article is structured:

— the universality of the problem

— a new phenomenon gives rise to a new migrant

— a comprehensive view

— the aspect of health care

— the Church's presence alongside migrants

1. The Universality of the Problem

Historical Notes

With the rise of the monumental civilizations in the third millennium B.C., the concept of migration as we know it today, allowing for the necessary modifications, appeared.

Indeed, in the preceding periods the transfer of homogeneous groups of individuals reflected the need for survival in the face of natural events rather than the desire or obligation to settle in different territories. In other words, the times elapsing between successive moves of tribes or family clans were not sufficient to enable a culture or anthropological conception to be formed which was capable of being exported with the movement itself. In the Neolithic age, we in fact recognize the megalithic culture of western Europe and the Tripolitan culture of the Balkan area, but these never faced each other since the movements fall within a short range and exhibit a nomadic character.

After the "universal Deluge" (which coincided historically with a period of repeated floods and volcanic eruptions), the construction of dykes and canals in Egypt and Mesopotamia gave rise to the water-based communities of Wittfogel, which appeared precisely on the banks of the great rivers: the Nile, the Tigris, the Euphrates, the Indus, and the Huang-ho. A premise for life was the solidary performance of community tasks: different professional strata took shape, and those exempted from the economic system of food production could devote themselves to other occupations, such as worship, handicrafts, and technology — i.e., a differentiated society was formed based on the city, the cradle of the new civilization.

All of these communities felt a need for territorial expansion and turned into empires in which a shared mode of thought and sentiment asserted itself, grounded upon linguistic, religious, and cultural factors.

Intense commercial traffic fostered mutual influences and contributed to the spread of the various cultures over vast areas. Jericho, the biblical protocity, in fact arose at the crossroads of the leading caravan routes, the stage for the first migrations in a modern sense — i.e., the transfer from one place to another of the product of the organized community life of many men which has been circumscribed to a given territory.

On the basis of this definition, we shall endeavor to offer a bird's-eye view of the outstanding moments of migration at different times, attempting to stress the special characteristic of each in relation to the period in which it took place, while bearing in mind that to furnish more than a brief description would exceed the confines of this account.

An initial example is the Babylonian captivity of the Hebrew people in the sixth century B.C., along with the occupation of Jerusalem as a result of the alliance between the kingdom of Judah and Egypt; the pages of the Book of Exodus describe much better than we could the drama and the adverse circumstances experienced by the Chosen People.

On the sea routes, Ischia was the first Greek settlement in Italy, during the second (Greek) migration, following after the earlier Aegean one, around 1250 B.C. These movements took place according to the dictates of the Delphic oracle, who performed the functions of population control by regulating wars, famines, and emigration.

Rome, with its empire, prompted an enormous influx of customs and cultural values into the Eternal City through its legions and the inpouring of peoples to augment the work force and the military.

The Slavs, Germans, and Turks subsequently destroyed the monumental bureacratic-administrative work created by the Romans, breaking up the Empire's military cohesiveness as well and opening it towards the north and the east. Normans, Vikings, and Arabs thus penetrated into southern Italy, with a marked and long-lasting influence on Mediterranean Europe.

In the early Middle Ages a further migratory element was constituted by the European fairs and trade routes, the oldest of which reached Sampagne, France.

Other specialized types of movement involved the wandering clerics, companies of medieval students from whose guilds the first universities were to arise, and the pilgrims — setting out for the Holy Land, Rome, and Santiago de Compostela — who, with a walking stick, mantle, and knapsack traveled the roads of all Europe towards the respective sanctuaries.

The Thirty Years' War, purportedly a result of conflicts among the Hapsburgs, was really a dispute over European hegemony. The contending forces were heterogeneous and diversified. On the battlefield were

— soldiers of fortune commanded by mercenary captains, of whom the Catholic army of the League was largely composed;

— the Spanish army, with a methodical combat tactic, the "Spanish square";

— the Wallehstein army, without professional unity, whose motto was "War supports war";

— the Swedish national army, equipped with muskets and culverins, which would become the terror of this conflict.

Never was the equation "foreigner = danger" so valid as in this turmoil of peoples and gunfire through the cities and towns of Europe.

Another fundamental stage was represented by the Pilgrim Fathers on the Mayflower reaching the shores of Massachusetts, and the foundation of Maryland after Sir Walter Raleigh had founded Jamestown, Virginia in 1607.

Finally, we may cite the forced migrations of the nineteenth century involving Black Africans — the large-scale deportations which constituted a real explantation rather than an uprooting. These individuals were granted nothing, not even a name; they were deprived of their personal and historical identity. And yet this factor did not succeed in denying fame to one of the sons of those deported — Malcom X.

The New International Migration

From these brief historical notes a dominant motif present in the migratory flux up to the beginning of this century is evident: people left an overpopulated Europe for new and far-off lands to be civilized, exploited, and dominated.

This process underwent only a slight decline in the interwar period, for reasons easy to imagine. The great novelty of the migrations of our time lies in the fact that only a few years after the second world war, the balance of the groups moving away from and towards Europe decidedly shifted in favor of the latter. Though the flow of Europeans towards the myth of the American dream, the white countries of the Commonwealth, and the ready earnings of Latin America continued, there was a constant increase in individuals from developing countries, those at war, and those ruled by dictatorships. They came to sell their labor cheaply in nations already receiving waves of immigra-

tion from the European countries themselves. In an initial phase these target countries were France, Belgium, West Germany, and Switzerland

The phenomenon later affected the very European countries which produced emigration — Italy, Spain, Portugal, Yugoslavia, and Greece, together with the nations in which the flux was totally reversed, Great Britain and Holland

It is estimated that in this century about 140 million people have left their countries of origin for new lands; we cite this piece of information precisely in attempting to provide a tangible index of the scope of human movement worldwide making up what we have termed " new international migration. "

2. A New Phenomenon Gives Rise to a New Migrant

The old aphorism stating that " one's own movement is movement of another " is valid for the predecessors of the new internationa migrations The aspect of relativism in encounters among human civilizations is highly significant for the latter, in the sense that not all of them had the capacity to make intercontinental moves on such a large scale

The new fact of the vast movements of this century — especially after the second world war — is that all populations have the means to effect massive shifts which are not at all dictated by a desire or need for cultural expansion, but, on the contrary, are prompted by the mythicizing of another culture and civilization which seem to be able to offer opportunities that would otherwise be out of reach.

It is this characteristic, above all, which has made the migration problem complex at present — that is, the interconnection of the motives spurring millions of people to leave geographical areas with raging social conflicts, wars, famines or droughts, racial discrimination, natural catastrophes such as insect invasions, serious forms of pollution, and all the other causes we have sought to outline in the brief geographical notes on the countries generating emigration.

The motives " .. have multiplied since 1974, when, in a foolishly short-sighted manner, the end of mass migratory processes was internationally declared. What was in fact meant was that the host countries for migration no longer felt the need for manpower which had led them to regulate the influx to some extent with a view towards limiting or deferring recognition of the rights of the newly arrived... Then, in 1974, people pretended not to be aware of problems such as those deriving from population imbalance, from the differences in economic, social, and demographic development between the world's North and South, and from the spread of the phenomenon of hidden economies, of which the exploitation of man becomes a dependent variable. "[1]

This is, then, the most significant novelty of the phenomenon: these new emigrants are simply condemned to underemployment, clandestinity, and marginalization. The inevitability of this lot provokes attempts at repeated moves to different countries — especially in Europe — perhaps with the idea of settling definitively in nations on other continents, such as Canada and Australia. The new figure of a migrant " in transit " is so characterized, as manifested in the global phenomenon of an original form of nomadism which does not turn the most developed countries into goals, with the mirage of well-being and integration into society, but preferred, transitory — and in some measure mandatory — stages on the way to a yearned-for promised land

Deeper analysis is needed to comprehend that this new nomadism can only partially be superimposed upon the meaning generally attached to this term — indeed, the former nomadism and the contemporary variety are similar in some respects and different in others

" A common characteristic is that both, in search of new goods for life, are implicit invasions with which the presence of ' the horde ' is associated — an event which seemed to have been overcome forever with the European *belle époque*. In the most isolated places in every time there has been a tendency to incorporate oneself into the main cities to enjoy the already established institutions which not without effort determined the progress of civilization; in this regard, the historical rebirths of peoples have been numerous and incessant. On the other hand, the fact has also arisen that a sector of the population has remained subject to indigence

" The differential aspect is that, in the face of political repressions, contemporary nomadism has progressively taken on the weight of an awareness of freedom. The sign of this cross of races seems to be the enjoyment of a liberty which has been lost or, in many cases, never possessed. If we join this freedom to human dignity, we observe a current fostered by an incessant crossing of races: this transit, which is accompanied by the indigence of the poor countries and the increasing scarcity of population in developed nations on account of contraception, becomes extremely painful. The free nations suffer under the weight of a heavy burden: their political, economic — and, above all, moral — crises themselves give rise to a form of insecurity provoked by the ' horde ' spirit in the younger generations. The sign of this ' hordism ' is reflected in organized traffic in the most serious vices, which culminate in a very high rate of delinquency. A large percentage of this process of delinquency must be attributed to a lack of mental health, from which, as a result of complex circumstances, delinquents themselves suffer. "[2]

3. A Comprehensive View

Population mobility is as old as man and has produced a fruitful spreading of civilization and cultures; from the encounters among them there has often come mutual enrichment for the ethnic groups confronting one another, though at the price of harsh conflict and sufferings.

The previous dynamic of large population movements in fact contained the inner finality of exporting and implanting a characteristic anthropological conception, within a perspective which may be termed an ethnological transplant. This characteristic remained unchanged for the migratory flows until those we have called the new international migrations. Today it cannot even fancifully be applied to the immediate — and principal — motivations for the movement of persons; we would say, even more, that the basic elements are lacking in order for an exchange to take place — a two-way exchange, to be sure, but one clearly favoring immigrants, comparable to that which occurred in preceding periods. The new factors explaining this change may be simplified as follows:

— poorer peoples are moving towards richer ones;

— " primitive " peoples are heading for those which are " evolved ";

— these persons have no possible cultural advantage in relation to their hosts.

It cannot, on the other hand, be denied that the problem of the new international migrations has painful aspects which are often manifested with the acuteness of extreme degrees of intolerance — if not outright xenophobia.

These deplorable attitudes, though unacceptable, are comprehensible and reflect the mark left

on society by the new immigration:

— the newly arrived will have an effect largely on the living conditions of the lower classes of the host populations, which are universally hardest hit by the classic woes of western society;

— the immigrants sell manpower at a discount, thereby reducing the earning power of natives in the services sector;

— the migrants represent the " new poor " of evolved societies, the scapegoat for constant oppressions which are the fruit of rampant discontent among these living in the grip of indigence, unemployment, lack of housing, and marginalization, who pour out the frustrations and humiliations to which they are subjected in the society of equals by moving against those who — just imagine! — are different;

— these foreigners accept, at least initially (which does not, however, mean for a short time), living conditions that barely guarantee their survival and at the same time provide opportunities for uncommon — and enormous — earnings to those sufficiently unscrupulous " to offer vinegar for lips burning with thirst. "

In any event, the above-mentioned elements represent only one of the perspectives in which it is possible to approach the social problem of migrants in order to furnish an overall description. Indeed, another would involve speaking of the ethnic minorities with a high education level from the areas of the African Horn or of fugitives (for that is what they are!) from countries where social conflicts are so harsh that they compromise the future as well as the present.

In summary, we feel it is appropriate in this discussion to sketch the dominant structure of the complex factors modulating the impact of immigrants on the societies receiving them and of the elements intervening decisively in the dynamics of the so-called integration process; in addition, it is fitting to indicate the points of departure for effective action to control the human cost imposed by social interaction with immigrants.

1) The psychological situation, with all its social implications, is one of the basic problems assailing the migrant. It generates anxiety, deep uncertainty affecting daily life more than the lack of a job or housing.

2) Information decidedly affects the immigrant's problematic. It is evident that the alarmist sensationalism of the press — with headlines such as " Italy: Europe's Soft Belly, " or " An Avalanche of Requests for Residence Permits, " or " Uncontrolled Entry of People from Outside the EEC " — does not foster a climate of acceptance on the part of the population.

3) The problems of integration supersede the ethnic diversities of all the immigrants; the obstacles to establishing a relationship of equality with natives shatter every prerogative for civil coexistence.

Finding housing — even before the question of calibrating economic means — demands recognition of the right to live in that place; obtaining a bureaucratic permit, in addition to involving a very complex procedure, means coming out of clandestinity; looking for a job or a school for one's children, prior to the matter of suitability for work or learning, requires a decent knowledge of the language, beyond the minimum sufficient for survival.

The integration of immigrants, in the light of these factors, presents itself as a multidimensional event in time, which ought ideally to be examined from the period prior to migration to seek out the motivation, expectations, agreements, and family connections involved which so deeply affect the climate of acceptance and incorporation into the host society and represent the commodities initially exchanged in the process of cross-cultural assimilation.

4. The Aspect of Health Care

General Focus

Our first goal is to offer a summary presentation of what we feel should be understood to be migration medicine. If we start by thinking that it is the nth extension of medical science as technology, a therapeutic approach and consolidated clinical practice, the future of the health problematic of migrants will soon become conflictual and contradictory.

The health of immigrants, if disengaged from a global vision of the factors conditioning it, will eventually be expelled by medicine which is " functional in terms of the increase of maladies rather than in view of a science of man and life "[3]

Migration medicine cannot and must not be this alone; rather, it must traverse the narrow limits of the western approach, which simply silences the object of its attention. It must open itself to contact with the other, the alien, the different one; it must confront mental and anthropological frameworks which, though shaking the classical canons of reference, at the same time enrich and condense them.

For immigrant patients the western way of expressing health problems may have even dramatic effects, for, with their avoidance of discussion of the culturally specific manifestations of being ill, a relationship of indifference and extraneousness is established towards what " health " and " illness " mean for them. To an immigrant patient it is more important to know where an illness comes from (aetiology), whereas a native patient is instead quite eager to know what disease is involved (diagnosis). In addition, the migrant manifests his sufferings in a markedly emotional way, openly displaying a longing for attention which the western patient regards as exaggerated and lacking in reserve, since he is more willing to bear his disease patiently without excessive complaints.

At universities the initial encounters with clinical medicine seek to awaken the student's curiosity — rendered sluggish by pages and pages of treatises — concerning man, the patient; they attempt to prompt unfledged wings to take their first flight outside the nest of books towards the sky of the person, understood as the unity of spirit, psyche, and soma, and not just an ordered set of organs and apparatuses. Well, medical science should show the same recklessness today in taking a leap from the wait-and-see approach arising from the conviction of its irrefutable validity — based on certainties deriving from scientific experimentation — to plunge into the multiform universe of the other, filled with different, unfamiliar life dimensions deeply affecting the manifestation of pathology and the latter's impact on the individual's experience.

With no need to turn in thought to the Nepalese ecstatic healers or the shamans of the North American Indian tribes, we can recall our own " healers " closer to home, in whom a great many people in our highly western world to this very day place their trust. With all the more reason, the magicians of African populations and the analogous figures in Asian ethnic groups enjoy the same acceptance; these are individuals who, moreover, find their prestige legitimated in society in proportion to the effectiveness they demonstrate. Let us recall that even very ancient documents traced back to the Sumerians bear witness to the very heavy punishments inflicted upon defaulting " health professionals, " who paid the penalty in terms of the law of retaliation for

empirical medical practice, still at an embryonic stage

The reason for the reliability of such personages should, in any event, be sought out beyond the real benefits of which they are capable — to be exact, in the total relationship they build up with patients: a relationship made to man's measure, conscious of his historical and social context and sympathetic to his life experience, so impregnated with peculiar symbols, codes, and representations.

It would not at this point be respectful if we failed to point out that recently official medicine's interest in " magical " or " traditional " forms of medical knowledge has been taking shape, an interest also manifest in the growing efforts of ethnologists, psychiatrists, and anthropologists and the number of conferences on this topic which are being organized nowadays.

This means that we can no longer ignore the fact that certain long-established prejudices concerning traditional medicine are currently being reviewed, in an attitude of serene, objective critical appraisal, in the light of modern scientific theories, which support and legitimate health conduct based on mere anthropological intuition.

Migration medicine ought to constitute the reappropriation of the most human roots of the health art; it must plunge deep into the individual's interiority, probe his human dimension, to grasp the *hominem dolentem*, without astonishment if it should realize it is touching upon the spirit.

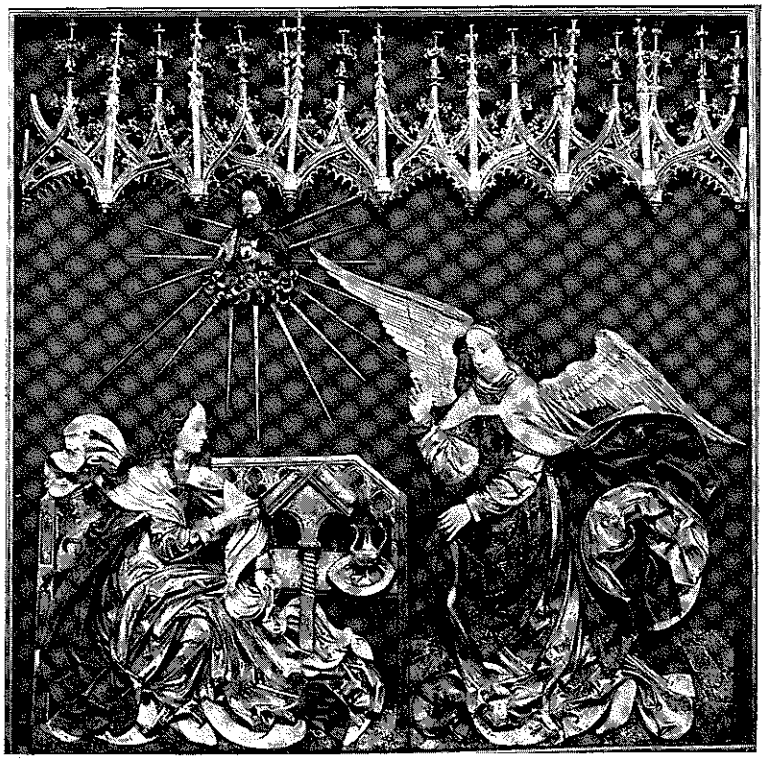
Medical Pathology

" When illness, which is essentially the very negation of the immigrant, eventually constructs — provided it is challenged — a new alibi for him (a substitute alibi, since the first one, work, has been destroyed by illness), as if by a strange paradox it becomes inseparable from the person affected by it; and it can thus disappear — that is, be cured — only if the immigrant no longer needs it, if he finds a solution to his malaise and contradictions — elements which illness reveals or sharpens. In the absence of a way out, illness becomes permanent and is permanently vindicated; it becomes the only way out of a situation which has none.[4]

The importation of extremely rare disease into our northern climes, whose causes are found in the increase of international tourism in general and in migratory flows in particular, for popular journalism represents one of the alarmist aspects of public health

This viewpoint is, however, evidently unilateral, since immigrants' physical vulnerability while staying in intermediate or target countries notably increases, as does their susceptibility to pathogenic *noxae* which at other times could be disregarded by them.

To describe the health status of immigrants — that is, a population which escapes ordinary statistics — is a titanic enterprise, both for purely practical organizational reasons (it continuously increases; it is highly unstable for observation; only a very small portion of it can be monitored, and so forth) and in view of strictly theoretical considerations (it is not possible to present data apart from estimates based on population samples,



which, as we know, are susceptible of more or less significant fluctuations).

It should also be stated that in statistics and epidemiology, we reason on the basis of " rates " which, in order to be decisive, require a denominator representing the value of the whole population, which, as has been repeatedly affirmed, cannot be identified with certainty. In addition, in presenting an epidemiological analysis it is necessary to refer to those objective conditions which are important variables in the manifestation of certain pathologies. It is evident that the pathologies found in Europe's Mediterranean area differ somewhat in quantitative distribution from those observable in the countries of northern Europe, where the climatic, dietetic, and geomorphological framework exerts a peculiar and divergent influence.

It is necessary to consider the importance of factors such as departing from tropical or equatorial regions for temperate zones lacking the thermic oscillations (ranging between 20° and 30° C over twenty-four hours) which are probably quite important for reestablishing nyctemeral vegetative balance and which migrants' genetic structure marvelously controls. They are obliged to ingest doses of preservatives and other additives for which they have not yet been selected; and, furthermore, they need to consume combinations of food substances which are improper or unbalanced for them (if they have the possibility of a " western " diet).

The first scientific temptation in approaching this problematic is to verify the existence of specific pathological patterns among different population groups on the basis of origin; such a demonstration would permit the delineation of a further peculiarity of migration medicine: a geographical medicine overturning the logical relationship of descriptive epidemiology and subverting the connection, in ordinary mental frameworks, between pathologies and their geographical distribution.

The second chapter of the *Report to the French Minister of Social Affairs and Health* in 1986 deals with " imported pathology ". It is mostly devoted to infectious diseases, whose association with

different significant parameters is studied. The authors conclude that this pathology is acquired almost exclusively in the host country and is related, above all, to the immigrant's terrible living conditions. They have, furthermore, regarded the risk for natives as very low and, in any event, constituted by a spectrum of pathologies for which proven therapeutic countermeasures exist (malaria, spirochaetosis, some parasitoses)

For the purpose of effective health programming, the type of question emerging from the general epidemiological picture supplied by careful examination of the literature proves to be of prime importance First of all, the absence of chronic/degenerative diseases — as is to be expected in populations with a rather reduced average age — stands out, excluding the need for particular forms of care which are the most widely demanded in developed countries.

In addition, the phenomenon of immigration is geographically structured in a way which is anything but homogeneous, in such fashion that there are areas in which the demand for health care is almost negligible and at the same time others where the need for care makes a very violent impact: we are referring to large urban hospitals and particularly to emergency wards It thus becomes extremely problematic to calculate the number of those using facilities assigned to the diagnosis and care of immigrants' deseases, as a result of the enormous variability of the population gravitating around the large urban centers, and particularly because it would be very hard to estimate the degree of knowledge of and access to such facilities on the part of immigrants.

To make a diagnosis does not, moreover, necessarily mean establishing effective therapy, and we are all familiar with the discrepancy existing between diagnosis and therapy as a tendency of current medicine: if, on the one hand, the most advanced technologies allow us to lay bare the most sophisticated pathologies, we witness an inability to treat them opportunely, on the other These " failures " weigh more heavily upon immigrants: when we are faced with spinal disorders or gastrointestinal syndromes with a clear psychosomatic origin — which become protracted and are resistant to common symptomatic therapies — it proves hard to identify diagnostic responses corresponding to the subjective sufferings of the patient. Not infrequently such situations result in the creation of labels which are hardly flattering to the immigrant patient and once more bear witness to how uncomfortable his demand for health care is; there is thus talk of " complaint psychopathy " or " the neurotic demand for care, " two phrases demonstrating the aggressive polarization of the doctor-patient relationship, " generally because the doctor has overlooked something or has a conception of illness and health that does not correspond to his patient's. "[5]

And this is not the only situation in which misunderstandings and frustrations appear; even when the immigrant has received an " education " in being a patient in the most precise Western sense, one consequence of his health ingration is the burdensome legacy of technological need on returning to his country of origin. This marked technological dependence, which clashes with " weak social linkage, " undermines the reconstruction of interrupted social relations and conditions the adjustment of his new lifestyle to local standards

" On an istitutional level, the returning emigrant discovers that local health institutions do not seem to be very interested in reconstituting his work capacity. He wastes a lot of time on simple laboratory tests — just the opposite of experience in the host country, where people tried instead to reduce his absence from work on account of sickness to a minimum. And he also feels the lack of the expenditure of diagnostic means and of the invasive therapeutic interventions he has come to know outside the country To obtain them, he travels to the large cities of his nation, where he hopes his illness will be treated better.

" Socially, it is hard for him to make his nonemigrant acquaintances understand the relation, which is important to him, on account of the work done there and the consequent illness It is as if the technological codes of relation to illness learned by him through links to foreign healthcare institutions had deprived him of the social experience of illness and the capacity for social bonds in this regard.

" The illness which in another land had always been evaluated in terms of work capacity and which could be the source of invalidity replacing work no longer seems such in his own country "[6]

Psychiatric Pathology

The psychopathogenic effects of large-scale population shifts on mental health have been demonstrated by several authors. There currently exists a significant body of psychiatric literature indicating the psychological consequences for individuals thrown between two cultures or undergoing the unpropitious experience of cultural domination.

These implications are considered particularly by those who are in such a situation not by their own choice, but as a result of the most varied factors, which have made the occurrence of this conflict inevitable; data bring out the fact that precisely in these the consequences of being uprooted become more serious and may precociously produce the decay of the subject's personality. To understand the psychopathological meaning of " moving between two cultures " it is necessary to bear in mind two key points which appear incontestable to researchers today " The first concerns the measure in which it is possible to maintain the language, values, cultural tradition, and preordained patterns of social relations; then there is the question of the voluntariness of contact acting upon the second problem most people have to deal with: isolation rather than participation. Both factors affect the strategies adopted by these persons — or those which the nature of host societies imposes upon them Those societies which encourage or permit the maintenance of traditional culture and allow groups to serve and act as social support networks for their members typically manifest lower levels of mental health problems among immigrants as compared to those opting for assimilationist strategies. "[7]

But even before discussing the consequences of the psychopathological risk it is appropriate to make some introductory remarks on the peculiarity of psychiatric diagnosis in patients such as immigrants.

Most people are aware of the magnitude of the problem of pathoplastic influences in psychiatry; it has been maintained that some symptoms and traits of neuroses and psychoses remain unchanged in time; pathological manifestations are, however, said to undergo the influence of the " spirit of the age " over the course of the centuries, of specific fashions or lifestyles shaped by given " social atmospheres "

Cross-cultural psychiatry is concerned with comparing different cultures and societies for the purpose of describing the effect on mental health of differing anthropological patterns, precisely by studying varying psychopathological manifestations in diverse populations.

Are mental illnesses universal? In the face of the problematic of new international migrations, such a question is posed in spite of all academic pedantry, for it is really the reply to this which will condition all correct action by health professionals. The leading classi-

cal syndromes themselves manifest significant cross-cultural differences; if there are few as regards schizophrenia (in Hindu culture, for example, catatonic rigidity and negativism prevail, interpreted to be products of a society tending to favor introversion, as opposed to the aggressive manifestations predominating in Western schizophrenics), there are more for manic-depressive psychosis (primitive peoples experience profound affliction followed by sudden recovery, for instance; Greek and Roman artistic works tell us, on the other hand, that such psychoses "did not emerge from a natural perspective," according to Ey, Bernard, and Brisset; in our culture, instead, the importance assumed by guilt feelings shows broad fluctuation).

Even more important is familiarity with some syndromes specific to certain cultures. We shall cite some examples.

— fever among eighteenth-century sailors;

— running among the Malay Amok;

— Windigo psychosis among Canadian Indians;

— swift and slow psychogenic deaths.

From among the specific neuroses we should mention

— *latah* in Java;

— *myriakit* in Siberia;

— *imu* in Japan;

— *koro* in Southest Asia

This very brief overview seeks to provide a sketch of the extreme variability emerging from contacts with immigrants undergoing psychiatric care; even more, it serves to bring out the aforementioned need for very solid cultural baggage of an interdisciplinary nature on the part of the physician and, more importantly, the psychiatrist.

Furthermore, situations like those of immigrants, characterized by environmental disorganization and the instability and inconsistency of social roles (for instance, young children who, in learning the new language more easily than their parents, very quickly take on a hitherto unknown importance within the family!), presumably foster the psychiatric pathologies which can manifest themselves with all the particularity of the culture of origin.

But are there pathologies typical of the immigrant's condition? The literature reports "homesickness psychoses" and asthenic states from deportation, but the syndrome of uprootedness must be stressed as primary in every sense. It involves personality alterations caused by separation from one's affections, practices, and customs and a reaction to the new environment surrounding the individual.

This syndrome includes a loss of initiative, a lack of a sense of time because of the privation of all activity with a practical aim, and the progressive deterioration of social capacities and interpersonal relations. Such a syndrome, rather than a terminal condition, presents itself as a factor aggravating the psychopathological risk of migration, often acting as an element precipitating latent pathologies.

German authors have pointed out that the phenomenology of the disease seems to go through alternate phases; whereas in the first stages symptoms of depression prevail, in the later ones marked psychosomatic pathologies become manifest instead.[8]

This aspect is of notable importance, for it suggests an interpretation: depressive reactions triggered by the initial experiences of emigration do not disappear in time, but, rather, evolve into psychosomatic syndromes. The shifting of problems from a psychosocial to a physical level finds an explanation in the attempt to normalize one's life situation. However, this is clearly an unintentional adaptation mechanism falling within the vaster domain of buffer systems activated by the mind to overcome limit conditions, in order not to see contradictions and avoid sudden and excessively costly changes. One author termed this phenomenon "adaptive preference formation," uncovering its dangerous manipulative aspect: "It makes men happy with the little they can obtain."[9]

What are the psychiatric disturbances most commonly found among immigrants?

What are the apparent psychopathological risk factors?

What is the approximate prevalence of major psychiatric disturbances among these individuals.

A reply to such queries cannot prescind from the risks involved in all generalization, but we feel we are not straying far from the truth if we say that the overall prevalence of psychiatric disturbances is not excessively high (only slightly higher than the 15% estimated for a general adult population), even though there are statistically significant differences for specific population groups of immigrants when compared to autochthonous controls. In addition, the incidence of major psychiatric disturbance often proves inferior to that of the host population, signifying that it is often the best endowed persons who leave their countries of origin.

As far as psychopathological risk factors are concerned, it has been stressed that sex is readily correlated to the onset of pathology. For some populations, such as the Eritreans, it is the female sex — since it is linked to both the woman's role and the occupation she finds in the host country; for others, the male sex may be a risk factor, as with the Senegalese, marked by a male majority and the subhuman living conditions to which they are subjected.

Prolonged stays in host countries, the advanced age of individuals, the level of education, and the type of work have been shown to be additional circumstantial factors related to the onset of psychic disturbance.

The Bioethical Aspect

The subject of the defense of life is being encountered ubiquitously in academic discussions and televised debates, where people fervently take sides on genetic engineering and its prospects in the coming decades, the right to life, and responsible procreation. It is paradoxical for official medicine to leave aside the vast problem of decent care for immigrants: if the defense of life is an indispensable right of the individual it must, with greater reason, signify the defense of the life of groups of individuals living in conditions of complete marginalization in large cities in Europe and elsewhere, to which they are propelled from the third world countries.

It is very strange that at a historical moment such as the present, when people are working to restore to the medical act its primary dignity as an ethical act, attention has not yet been paid to the disavowal not of individuals, but of whole populations, as if signifying that large numbers or the size of an economic intervention takes importance away from the ethical dimension of the problem, forcing it into an exclusively political space. In fact, if euthanasia and abortion are a very serious attack on what is most human in the art of medicine, even more serious is health professionals' abandoning millions of people who need physicians' comfort and care.

We believe that if a doctor can be accused of failure to provide care when he refuses to do all he can for his fellows, then the same accusation should be directed at the health corps as a whole in cases such as migration medicine, where, as stated previously, not only an individual, but an entire population is disgregarded. We should otherwise have to observe sadly that moral conscience and ethics are valid for the private do-

main, but the reason of State for the public one — that painful Machiavellian teaching.

" The defense of life must also mean health care for African expectant mothers, for all the children of immigrants, for all the sick of whatever nation, sex, or juridical status, " for it is the dignity of the human person which remains the obligatory referent for all sectors of intellectual, moral, and, above all, religious commitment. "[10]

Bioethics, then, is called today to take a position on this aspect — recent, but of ever-increasing significance — of the panorama of contemporary medicine, since, " if the interdependence of peoples and the observation that everyone is truly responsible for everyone else make solidarity an unavoidable duty and a basic Christian virtue, this principle must be applied to the field of medicine as well, because of both its growing and proper socialization and the problems imposed by socialized medicine "[11]

It will not escape the notice of careful observers that the problem of migration medicine by full right enters into the project for the health ministry based on instilling respect for a deontological code enlightened by Christian doctrine.

In our period of the hypermedicalization of society, in which there is discussion of the need for a specific medicine for every eventuality and it is thought honest to create miscrospecializations (basic medicine, tourist medicine, mass medicine, etc.), any kind of medicine for migrants is resolutely denied.

We are grateful to those responsible for the pastoral project aimed at health professionals for having provided a platform for such a fundamental requirement in relation to recovering the purest values of the medical art, in the certainty that even considering it restores dignity to the ever more numerous users of the volunteer clinics which, with the support of the Church, have been gradually established and that this gratifying attention constitutes an indispensable premise for realizing an authentic migration medicine.

Proposed Solution to the Health Problem

According to what we have stated in the preceding sections of this study, we must divide the health problem of human migrations into two main points: a) the lack of health care for immigrants in host nations resulting from the juridical and civil diversity, which, at least in the early stages of immigration, constitutes a real obstacle to health care; b) the cultural difference of the host population as regards the migrants, which brings with it the migrant's different way of expressing symptoms and pathologies and a different conception of the very role of health care and professionals.

As for the first point, it is evident how impelling the need is to place immigrant populations on an equal footing with residents in countries which have not provided for the care of migrants, for reasons of both juridical correctness and health policy. The nations which accept — if not formally, at least in practice, by tacit and resolute consent — the principle that the migratory flow from poor countries to rich must find an outlet in the permeability of borders cannot elude the obligation to transform a clandestine wave into a civic presence. In this regard, the first right is health care. Indeed, to use extreme terms, if on the way to immigrants' integration it is possible to conceive of an intermediate and temporary phase of contingency, it cannot dispense with health protection. The legal subtleties which allow migratory inflows without allowing them cannot avoid pathological situations which, in view of their acuteness and seriousness, cannot wait.

In economic terms as well, if there is intentionality in consenting to immigration involving an influx of manpower into the system of production, even before agreeing to a definitive legal equalization of this presence, from a health standpoint we must assist an acculturation which is so weak that it can turn into a social massacre.

At present, in nations like Italy, where there is no clear institutional awareness of the problem, the burden of health care for unintegrated migrants is borne by the Church or spontaneous aid. The quality, as well as the fragility, of such assistance cannot, however, be viewed with tranquillity. Rather than a response, it is a question of signs of sensitivity from which more solid intervention by public institutions must result.

On the other point — that is, cultural differences — it must be clearly brought out that it is not enough to provide just *any* medicine, but one which is aware of the fact that the great distance separating the two existential spheres — in terms of culture, faith, language, etc. — of the migrants and the host nation involves a real difference in the way of *expressing* illness and symptomatology and a peculiar way of regarding the roles of both the patient and the doctor. To prescind from such reflection means to accept a lack of understanding on the doctor's part in the diagnosis of illnesses appearing different and on the patient's part an incapacity to utilize the Western healthcare apparatus. The peculiarity of migration medicine does not consist of pathologies, but the possibility that the medical act will be diagnostic for the doctor and curative for the patient. Let us recall linguistic differences

alone, which make a correct case history nearly impossible, along with differences in sexual customs and in the conception of blood in African culture, as well as the stoic value of withstanding pain which is typically Judaeo-Christian. We can then observe the elements structuring the cultural anthropology of doctors and patients from different ethnic backgrounds which affect, in short, the very possibility of diagnosis and treatment

One might say that cultural differences are already present in a single nation which depend on differences in economic class It is evidently one thing to treat a patient from the residential quarters of Milan and quite another to care for someone working in sheep-rearing in the most secluded areas of Sardegna. In this sense, the most specific differences in relation to migrant patients depend on economic, not cultural, diversity In MacLuhan's *global village* the third and fourth worlds do not represent a cultural, but an economic difference If it is true that Western television culture now reaches the homes of residents of Kinshasa or the suburbs of Luanda, the immigrant might simply be considered isocultural as regards the shepherd of Barbagia. In practice, the third world would be a slum of the universal city, a slum whose inhabitants would be the poor people living under the bridges of the Thames, the Rio de Janeiro *favela*-dwellers, the North American homeless, and the lumpen proletarians of poor Roman neighborhoods

Such a vision, though rich in meaning, has ingenuous class connotations overlooking the weight of the ethnic group and traditional culture making up a people's *imprinting*.

Among other things, experience teaches that for migrants — Ethiopians in Italy, for instance — coming from the middle or upper middle class, although they are quite similar in studies and educational background and even possess a university culture based on European treatises and conceptions, a cultural residue of their own is inevitable, an inner autochthonous segment constructing life strategies full of Western meaning, but with their own methodology

The Western doctor must plunge into this cultural residue, not regarding himself as a neutral observer, with classical Cartesian faith in an emasculated rationality, but as related to that culture with his own — a foreign culture which appeared to have vanished into an isocultural environment, but which now shines forth with all its characteristic and differentiated forcefulness

If this lesson is assimilated, a medicine for migrants must be structured which is rich in cultural interface, with workers not only in tropical medicine, but, above all, in cultural anthropology, the geography of health care, and cross-cultural psychiatry, with publications in migrants' native tongues which will foster a rapid process of health acculturation as the basis for mutual understanding with a view towards better health and care.

May we be allowed to state, furthermore, that such action might stimulate reflection on medicine, which, for Western populations as well, must be able to recognize the specific differences whereby it is not only a science of bacteria and sick molecules, but a caring relationship with living beings marked by singularity.

5. The Church's Presence Alongside the Sick

" From this mobility of peoples there derives a new and vaster spur towards the unification of all nations and of the whole universe, in which it is easy to discern the Spirit of God, who with admirable providence directs the course of the times and renews the face of the earth. "[12]

Once again we must recognize and take note of the Catholic Church, which, first and foremost among the large institutions, has observed the significant transformations that have taken place in the world and have seemingly been discovered by everyone today. We have attempted to point out that the dramatic core of suffering in migration among those uprooted from their cultures of origin consists of and manifests itself in the anthropological character of the different civilizations contrasted.

Let us consider the case of African immigrants. Their culture is tribal: warm, open, not centered on the individual, but the group; the developed societies, on the other hand, set against it an individualistic mentality, a society in which the person is important in proportion to his self-sufficiency, and, moreover, depending on the degree to which he is able to use others to increase his self-assertion. This subversion of one's own tradition, however, is certainly not an exclusive apanage of African peoples, for it is precisely on the depreciation of man's value and the person's dignity that the ethical revolution all the immigrants are heading towards focuses.

In the patristic age, the Church was already manifesting her apprehension in regard to human mobility, and in this perspective the Council of Elvira spoke out at the beginning of the fourth century, agreeing to the naming of extraordinary ministers for the baptism of those in movement.

These were not the only instructions concerning the phenomenon of human mobility From the analysis of conciliar and later texts there emerged programmatic indications for the care of expatriates and refugees, concern for exiles, and the safeguarding of ecclesiastical asylum.[13]

To the spiritual needs of travelers, however, material ones soon came to be added, in a period still quite distant from the fifteenth century, which began to regard such activity as incumbent upon the State It was the Church, then, that, through the charitable action of her monastic and knightly orders, assumed the burden of the community's obligations towards its weakest and neediest members, and by the rule of *fratres in servitium venientes pauperum* initiated a program which would take concrete shape in the appearance and technical organization of the medieval hospitals. In addition to the mountain passes and points of landing and embarkation, hospices and shelters were erected which were granted privileges, exemptions, and broad administrative autonomy so they could perform their functions better.

Confraternities (which arose first of all for spiritual needs) themselves soon pursued aims of a material nature, particularly the care of the sick. From the hospitals there emerged orders playing a key role in checking frequent and very serious epidemics which were responsible for medical and prophylactic initiatives to diminish contagion and safeguard public health and succeded, above all, in showing respect for the sick and their dignity; the patient, " whoever he was, was the living image, in his sufferings, of the Redeemer, who suffered to save man "[14] Among these were the Order of Teutonic Knights, arising in a nationally oriented hospital for Germans who had been wounded or become ill in the Holy Land; the Order of St Anthony for the specialized care of the malady known as shingles and all skin diseases in general; the Order of St. Lazarus for the care of lepers, whose hospitals were located on the eastern outskirts of cities (as if to indicate where the disease came from) and on the major routes for international traffic; the Order of Tuscan Friars, in Altpoascio, devoted to St. James, protector of travelers and pilgrims, whose houses specialized in assistance to those in transit and were characterstically located near bridges crossing the most dangerous rivers.[15]

The sixteenth century witnessed the appearance of two of the most representative figures as regards the Church's commitment to the care of the sick and suffering, St. John of God and St Camillus De Lellis, who founded the orders of the St. John of God Brothers and the Camillians, organizations which spread throughout the world, thanks to numerous disciples who sought only to follow their Founders' example. If John found his cross in Granada, it was at St. James' Hospital in Rome where the fervent Camillus practiced his most humble service The two saints' charity and devotion to their patients, along with the immense fatigue and heavy sacrifice, eloquently witness to the ardor they managed to instill in their followers They were the real, most fertile seed which yielded two of the most imposing healthcare and spiritual edifices, which accompanied and oriented the development of a genuine medical system without frontiers. Many illustrious figures also belonged to these Orders. Let it suffice to recall Fr. Gabriel Ferrara, O H., the physician of Austria's emperors.[16]

In the face of so many brilliant examples it is superfluous to expand on the Church's efforts alongside the suffering. It is, however, worthwhile to cite the persons and facilities continuing and augmenting the work begun so long ago in our own day — Mother Theresa of Calcutta, for instance — who join the array of noble spirits devoting all their vital energies to the sick by virtue of a divine obligation.

The spirit of service the Church nourishes and lavishly bestows in the people involved in the great movements has, then, come down to our day, and it is significant that the subjects of migration and health care converge today as well, encountering the same responses as in past centuries.

Indeed, since 1952 the Superior Council for Emigration in Italy and the Maris Pastoral Insitute, created by Pope Pius XII, have provided for the pastoral care of migrants and spiritual assistance to Christians forced by necessity to live on boats and, later, the Coeli o Aeris Pastoral Institute offered abundant Gospel testimony to those traveling on aircraft as well. In 1965 Pope Paul VI founded the International Secretariat for Administering the Nomadum Pastoral Insitute, for the purpose of " bringing spiritual comfort to a population with no fixed dwelling and also to those living in similar conditions "

With the publication of the Motu Proprio *Apostolicae Caritatis*, of March 19, 1970, the different responsibilities of the aforementioned entities dealing with the mobile population were brought together in the Pontificia Commissio De Spirituali Migratorum Atque Itinerantium Cura, with the task of seeing to the study and application of pastoral care for " people on the move ": migrants, exiles, refugees, seamen, aviators, truck drivers, nomads, pilgrims, tourists, and those who, " for different reasons are involved in the phenomenon of human mobility, such as students abroad and workers and technicians who, on account of large-scale enterprises or research on an international level, must move from one country to another. " Since 1988, with the Apostolic Constitution *Pastor Bonus*, this Commission has had a new name: Pontifical Council for the Pastoral Care of Migrants and Itinerant People [17]

At a distance of half a millennium, the same need for assistance as in the past is joined to spiritual requirements which again seek responses beyond the confines of government action

The Church, then, which has been at the forefront in showing sensitivity to the traumatic and marginalizing potentialities of the cross-cultural psychological impact and has consequently managed to foster solidarity towards these members of the human family, is again called to be the driving force for every stimulus towards a solution — however arduous — to the drama of human mobility.

" This is a Christian hour as well The Catholic Church has distinguished herself since early apostolic times for her dedication to those less well endowed, to cause their personal and family life to progress within the social body. There is no hidden propaganda in asserting that the Church — if we review past centuries — has sometimes been the only power that has resolved problems in care, through the wonderful initiatives of the saints.

" With his miraculous healings, Christ left an indication of his promise to lavish a form of impalpable miracle — which proper effort merits — on those who, setting their hands to this task, devote their nobility to such a serious undertaking. From a Christian standpoint, the deepest root of human medicine is revealed by Him in the beatitude announcing, ' Blessed are the poor in spirit, for theirs is the Kingdom of Heaven ' (*Mt* 5:3). Christ, then, joined the two supreme forms of indigence: corporal and moral. Migration medicine.. should in no way exclude them.

" Forceful spiritual prophylaxis undoubtedly develops in individuals the capacity for initiative needed to face the effort required of so many human beings by contemporary life so that they may reach — in their countries of origin or in host countries — a healthy place which will favor their survival in fitting conditions "[18]

We feel it is important to reflect on these words, which accompany the technical dimension of health care with a markedly pastoral component.

Indeed, the Church, in making a commitment to immigrants, once again demonstrates that medical attention is not mere technical expertise or business management, where health is just an item on a balance, but dedication to the person beyond all questions of ethnic groups, ideologies, budgets, and declarations.

Christian health care, by way of doctors, nurses, and hospitals, does not defend life as an abstract, adimensional entity, but the life of the person, each patient with his individuality, freed from all standardization, and given personal attention because he has been personally conceived of and loved by God It is, in fact, the Church that must stress the substantial identity of the foreigner on the common road of history and in sharing the same human values, for the love of God is for all as his children, conceived of with particularity and originality, and it is this love which composes the deepest of relations among peoples, that of brotherhood.

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[1] F. Foschi, *Atti del I Convegno Internazionale su Medicina e Migrazioni*, pp. 10-16

[2] Fernando Rielo, " Messaggio Inaugurale, " in *ibid.*, p. 7

[3] Foschi, *op cit.*, pp 10-16

[4] A. Sayad, " Santé et equilibre social chez lez immigrés, " *Psycologie Medicale*, XIII, 11 (1981), pp 1757-1758.

[5] U. Beck, *Frankheit al Selbtheilung Wie Korpeliche Krankheiten ein Versuch zur seelishen Heilung sein konhen* (Frankfurt 1986).

[6] T Emmenegger, *Malattia e migrazione. Problemi dell'adattamento e del ritorno*.

[7] To get an idea of this study based on a sample of immigrants in Rome, it is worthwhile to consult M. Cuzzolaro and I. Frighi, " Il rischio psicopatologico in una popolazione di immigrati a Roma, " in *Atti del I Convegno Internazionale su Medicina e Migrazioni*, pp. 17-23, and B. Harrel-bond, in *ibid.*, pp. 42-52.

[8] H Hafner, G. Moschei, and M. Oesek, " Psychische Storungen bei turkischen Gastarbeitern. Eine prospektive Studie zur Untersuchung der Reaktion auf Einwanderung und partielle

Anassung, " in *Nervenarzt*, 48 (1977), pp. 268-275.

[9] J. Elster, *Sour Grapes. Studies in the Subversion of Rationality* (Cambridge University Press, 1983).

[10] Fr Alfonso Urrechúa Libano, " Messaggio Augurale, " in *Atti del I Convegno Internazionale su Medicina e Migrazioni*

[11] Address by Archbishop Fiorenzo Angelini at the Pontifical University of Chile, April 13, 1988, in *Dolentium Hominum*, 8 (1988), p. 64.

[12] From the Apostolic Constitution *De Pastorali Migratorum Cura*.

[13] Achille M. Triacca, S.D.B., *Preoccupazione pastorale e mobilità umana nella Chiesa ispano-visigotica*

[14] E. Nasalli Rocca, *Il diritto ospedaliero nei sui lineamenti storici* (Milan 1956).

[15] P. Brezzi, *Caratteri e protagonisti della spiritualità cattolica alla fine del Medio Evo* (Naples 1960).

[16] G. Rossotto, *L'ordine Ospedaliero di S. Giovanni di Dio* (Rome, 1950).

[17] *Annuario Pontificio 1989*

[18] Fernando Rielo, *op. cit.*

Bibliography

Anwar, M. *The Myth of Return* (London: Heinemann, 1979)

Bachet, M. " Etudes sur les etats de nostalgie, " in *Annales medico-psycologiques*, p. 21.

Baker, R. *The Psychosocial Problems of Refugees* (London: British Refugee Council/European Consultation on Refugees and Exiles, 1983).

Blest Gana, A. *Los trasplantados* (Paris, 1906)

Boyd, W.C., I. Asimov *Race and People* (New York: Schumann, 1955).

Camilleri, C. *Jeunesse, famille ed developpement* (Editions CNRS, 1973)

Cipolla, C.M., *Velieri e cannoni sui mari del mondo* (Turin, 1969)

Colasanti, R., M. Nonis, " La medicina dell'esodo: Assistenza sanitaria agli immigrati clandestini presenti a Roma, " in *Atti del I Convegno Internazionale su Medicina e Migrazioni*, pp. 58-65.

Duby, G. *Les trois ordres ou l'immaginaire du féodalisme* (Paris: Gallimard-Julliard, 1980).

Edwards, J. " Dialektik des Exil, " in *Autore in exil* (Frankfurt 1981)

Elias, Merton, Park, Schutz, Simmel, Sombart *Vicinanza e lontananza Modelli e figure dello straniero come categoria sociologica* (Milan: Angeli, 1986).

Ey, Bernard, Brisset, *Manuale di Psichiatria*.

Frigessi Castelnuovo, D. " Il modello della nostalgia malattia, " in *Antropologia Medica*, 4 (1988) pp. 53-55

Frighi, L., P. Carbone, C. Celli, M. Cuzzolaro, S. Marchini, A. Petrilli, A. Scavo, G. Vetrone. " Immigrati stranieri a Roma: Problemi di igiene mentale, " in *Quaderni Ital Psichiatria*, IV, 2 (1985), pp. 97-130

Gentilini, Brucker, Montvalon *Salute dei migranti. Rapporto al Ministro degli Affari Sociali e della Sanità* (Paris 1986)

George, P. *Le migrazioni internazionali* (Rome: Editori Riuniti, 1978).

Geremek, B. *Inutiles au monde. Truands et misérables dans l'Europe moderne* (Paris: Gallimard-Julliard, 1980)

Levy-Strauss, C. *Anthropologie structurale* (Paris 1958).

Maxia, C. " Le tappe fondamentali tecnologiche e sociali dell'Umanità dal Pliocene all'Olocene, " in *Rass. Med. Sarda*, LXV (1963).

Mollart, M. *Les grandes voies maritimes dans le monde: XV-XIX siecles* (Paris 1965).

Mollica, R.F., J. Lavelle, Svang Tor, C. Elias. *Turning Point in Khmer Mental Health. Immediate Steps to Resolve the Mental Health Crisis in the Khmer Border Camps*, prepared for the United Nations Border Relief Operation (1989).

Nguyen Bathien, K. " Adaptation psyco-affective et élaboration d'identité des enfants deplacés, à propos du suivi à long terme des mineurs réfugiés du Sud-Est asiatique, " in *Neuropsychiatrie de l'enfance*, XXX (12), pp. 691-693.

Panikkar, K.M. *Storia della dominazione europea in Asia dal '500 ai giorni nostri* (Turin 1972).

Park, R.E. " Human Migration and the Marginal Man, " in *American Journal of Sociology*, XXXIII (1929)

Rey, M. *Former à l'education interculturelle* (Strasbourg: Council of Europe, 1986)

Sandler, R.H., I.C. Jones (eds.). *Medical Care of Refugees* (Oxford University Press, 1987)

Sluzki, C.E. " Migration and Family conflict, " in *Family Process*, XVII, 4 (1979), pp. 379-390

Spini G. *Storia dell'età moderna* (PBE, 1982)

Zwingman, C., M. Pfister, *Uprooting and After* (Berlin-New York: Speringer-Verlag, 1973)

Medical Ethics: An Offspring of the Church

Introduction

It is a pleasure and an honor to address this gathering on the topic of medical moral theology. This is a particular pleasure for me because this is the one-hundred-and-fiftieth anniversary of Loras College. Chartered in 1839, in the reign of His Holiness, Pope Gregory XVI, the first bishop of Dubuque, the Most Reverend Mathias Loras, pioneered the mission to the mind in Iowa. This oldest college in Iowa has been called by many names: St Raphael's Seminary, Mt. St. Bernard. St Joseph College, Dubuque College and Columbia College. During the school's centennial year, the name was changed to Loras College. I am humbled to stand here tonight to address you on the one hundred and fiftieth anniversary of Loras College, in light of the brilliant intellectual heritage of this institution, the priests and lay faculty who have served here so selflessly and the past and present tradition of the Archidiocese of Dubuque

Historical Overview of Medical Moral Theology

Medical science has advanced remarkably in our own lifetime. Oddly enough, much of the technology of contemporary medicine evolved in conjunction with the exploration of outer space and its incumbent quest for specialized synthetic materials and machinery. Today, medical marvels are part and parcel of daily headlines and feature articles Despite its relatively recent arrival in the daily consciousness of society, medicine and the Church have had a centuries-old relationship, such that "medical ethics" or "pastoral medicine" became a distinct and well articulated discipline by the nineteenth and twentieth centuries. Catholicism's development of this discipline had no contemporary parallel within the Judaeo-Christian tradition, nor in philosophical thought at the time [1] This is not to say that there was no recognition of the need to be ethical in the practice of medicine beyond the borders of the Church The oath of Hippocrates is clear evidence of that. My thesis is that medical ethics is an offspring of the Catholic Church inasmuch as the Church has had the necessary qualifications and historical incentives to be its parent

There were two currents in the life of the Church that contributed greatly to the fact that medical-moral knowledge flowered so early in the tradition The first is the always present concern for the sick on the part of Christians. This concern was based on the Lord's life and work — the fact that He cured the sick. In fact, this later came to be articulated as one of the "corporal works of mercy." The Gospel attributed to Mark — which is considered by Scripture

scholars to be the first Gospel written — devotes a full third of its content to how Jesus cured the sick. In the Gospel of Luke, when Jesus sends the seventy-two on mission in chapter ten, He commands them to do two things: to heal and to teach.[2] [Interestingly, Jesus does not direct them to form parish councils.] Despite the fact that the NT presents His concern for the sick in the form of miracles, there was a realization within the faith that God usually works mediately, through secondary causes in the world and rarely by means of the miracle. Because of the Church's conviction that there can be no contradiction between faith and reason, the sciences have generally been promoted at least in principle while emphasis on the miracle has generally been downplayed because of its popular association with superstition and magic

It was this first factor — concern for the sick — that in fact gave rise to hospitals. In the subapostolic and patristic age, this mission to the sick was given to the deacons. Special institutions were founded, called " nosocomeia, " for the care of the sick. Pious laypersons also assisted in this task. St. Fabiola († 399), St. Paula († 404), St. Ephrem the Syrian († 373), and St. Basil of Caesarea († 379), the bishop who built one of the most famous hospitals of the period, known as the " Basiliad, " are names that come immediately to mind. In the West, the monastic reform of St. Benedict brought with it a strong emphasis on *hospitality*. Transient hospitality was offered to pilgrims and a more permanent hospitality was offered to the sick. This aspect became integral to monastic life. St. Benedict's *Rule* states: " The care of the sick is to be placed above and before every other duty. " Three famous early medieval hospitals were established around this time: Hôtel Dieu in Lyons (542), Hôtel Dieu in Paris (651), and the Santo Spirito in Rome (717). This concern for the sick was present in every age of history, which time will not permit us to trace here. But it should be said that some of the first hospitals in the New World were opened under the auspices of the Church: Jeanne Mance († 1673) came from France to nurse the Iroquois Indians and French colonists. This led to the opening of the Hôtel Dieu in Montreal in 1644. A group of Augustinian Recollects opened the Hôtel Dieu in Quebec, which was built by the niece of Cardinal Richelieu. Also, the Hospital of the Immaculate Conception was built in Mexico City in 1524 by Cortes at the command of the Spanish crown. This was actually the first hospital erected on the American continent.[3]

Priests — often the only literate persons in an area — pursued medical careers on a large scale as early as the sixth century. Because the time and energy demands of the double profession became so great that priests could not " serve two masters, " the clergy were forbidden to practice medicine by the Fourth Lateran Council (1215). This discipline was still in force until the new Code of Canon Law was promulgated in 1983.[4] (Exceptions were made on an individual basis for certain missionary lands.)

The second factor that contributed to the development of medical ethics in the Catholic tradition was sacramental theology. The sacraments of Baptism, Penance, and Matrimony all pose questions the resolutions of which require some medical expertise. The sacrament of Penance provided the larger context for this " interdisciplinary science. " Since faith is to be expressed in works, there is naturally an interest in the various duties necessary for one's state in life. Private auricular confession became the norm in the sixth century, and it soon became Church law that sins should be confessed at least once a year in number and species. The priest was to determine the existence, number, and gravity of sins in order to assign an appropriate penance and give absolution. The training of confessors, then, became " casuistic " or case-oriented.[5]

Many cases studied by aspiring confessors and many submitted to this sacramental forum dealt with medical issues: questions such as abortion, beginning with the classic question of whom to save in the conflict situation between mother and child. Such questions were directly related to Baptism, which is necessary for salvation. When does one have a human soul? What is the beginning of human life: What do we do in the case of the doubtfully human? Should we baptize monstrosities? Other medical questions arose in need of moral discernment: how can we justify surgery which apparently employs an evil means (mutilation) to achieve a good end (therapy)? This question becomes sharper in the case of amputation: does the end justify the means? (Not according to Romans 3:8.) Another set of questions arose over whether or not extraordinary means are always morally required or are only permitted — one of the original cases concerns whether an individual with a chronic disease which can be cured only by a drastic change of climate must leave his residence indefinitely — pehaps forever — in order to get well or stay well. Also allied to this complex of questions is the justification of transplants: how can these take place morally if, in the donor's case, mutilation is done for no personally therapeutic reason? The resolution of these cases depended upon the development and application of the well known principles such as the double effect, totality, charity, etc.

Today's questions are familiar to all of us but are no less perplexing than in former times. When do we pull the plug? When is enough enough? Are we morally obliged to do everything we are technologically capable of doing? Is good medicine always good morals? Some questions have not come to widespread public attention as yet. There are complex questions about experimentation (where the subject is no longer a patient). There are questions about free and informed consent — especially in cases in which we are capable of changing at least the shape if not the intelligence, health and very definition of humanity forever.

The Necessity of the Moral Question

We see a distinct thought process at work even within this brief overview of the tradition's history. There is something at work beyond the mere accumulation of medical knowledge. Within the sphere of human activity — religious or otherwise — there has been an attempt to examine and understand the meaning and impact of human actions. There has been in every age a desire to put the " music with the words, " to use Mark Twain's phrase. There has been an attempt to ascertain a quality beyond effectiveness and skill. This has been the pursuit of moral standards, a reflection upon our activity to determine the qualities we call right and wrong. Basically people take up ethical reflection to make sure that their lives meet the test of reasonableness. This kind of reflection has been undertaken in every age and in every culture. In the face of any practice or development in the sphere of human activity, the question of morality, " Is it reasonable? " has always been found to be appropriate.

The coordinates for determining the reasonableness of activity certainly vary from culture to culture and from one historical period to another; nevertheless, the ethical enterprise has always taken place, it has always been deemed to be more than a luxury. In fact, moral reflection and activity has been seen as essential to the genuine *humanness* of our humanity. One has only to recall the words of Socrates, who said that the unexamined life is not

worth living. Or, more personally, one only has to ponder the feelings of horror, anger, and disgust at the governmental policies of Nazi Germany.

A Distintively Catholic Enterprise?

Christians have their coordinates for determining right and wrong as well The Christian's thoughts in this regard turn first to the Scriptures — the OT, of course, where we find the Decalogue, but also, and especially to the NT, in which we find the doctrine of Christ laced with moral teaching: the " commandment " of love, the beatitudes Also, the writings of St Paul contain over a dozen lists of virtues and vices It is to the NT texts that Christians always return for reflection and direction, for inspiration and nourishment.

It takes no genius to realize, however, that there are many questions we have that were not posed in the NT — indeed, questions which the NT mind and experience could not even articulate. It soon became evident to Christians that Christ's revelation was more than a moral doctrine. St Thomas Aquinas taught that the " new law " or the the " Law of Christ " added nothing new to the natural law morality The *locus classicus* of his thought in this regard is form I- II *Summa theologica*, Q 108, A 2 He says, " the New Law had no other external works to determine, by prescribing or forbidding, except the sacraments, and those moral precepts which have a necessary connection with virtue, for instance, that one must not kill or steal, and so forth. " He explains further in the response to the first objection that while matters of faith are above human reason and therefore depend on grace to know, " it is through human reason that we are directed to works of virtue, for it is the rule of human action. Wherefore in such matters as these there was no need for any precepts to be given besides the moral precepts of the Law which proceed from the dictate of reason. "

Very practically, to think that Pope Paul VI's intention in *Humanae Vitae* was to offer a specifically Catholic or Christian solution to the problem of birth control is clearly naive. A careful reading of the Pope's encyclical makes it very evident that he in no way intended to provide a specifically Catholic resolution for a universal moral problem. By appealing to a universal moral law — not one available to the world *only* by divine revelation — Paul VI could reach the audience of non-Christians as well, and put before them a *humane* solution to a human problem.

Therefore, it is said that Christian revelation adds nothing to the " content " of morality, but its distinctive contribution to morality resides precisely in its direction or intentionality I think this overstates the case. Ethical reflection which derives from faith in Christ, has in fact always offered something distinctive, and corrective, to public debate and philosophical reflection It has been prophetic without being gnostic.

As believers, our morals have been strongly influenced by our faith It is faith in a personal God who created and redeemed us in love. The dogmatic and moral aspects of the one faith are capsulized by the words of St. Paul, " to have that mind in us which is that of Christ Jesus " Moral theology is *theology*: " faith seeking understanding " Theology (including moral theology), therefore, has explicit supernatural referents as objective principles These include a transcendent God, a supernatural destiny which is unknowable by unaided reason and unachievable by a moral act without grace. For this reason, Pope John Paul II has said that " only *theological* ethics can give an entirely true response to the moral questioning of man " " Christ the Redeemer fully reveals human beings to themselves "[6]

The Holy Father's point can be understood this way: For all its naturalness, natural law morality derives from radical faith in the Incarnation — that humanity fell no further than Christ descended and that His creation, though wounded, was not ruined by the moral catastrophe of sin It is precisely at this point — really, this doctrine of grace — that Catholic faith and theology part company with the Protestant Christian perspective, and join the ranks of the " humanists "

This is not to say, however, that Catholic moral theory has uncritically absorbed all the intellectual developments of the early modern and contemporary periods In fact, in any age, the Catholic theological " digestive system " attempts to nourish itself by " consuming " or analyzing " what's out there, " but always with a view to " metabolizing " the material according to its own organic structure and designs. A skeletal overview of this Church/world conversation in modern times may be instructive.

Contemporary Intellectual Milieu and Its Historical Roots

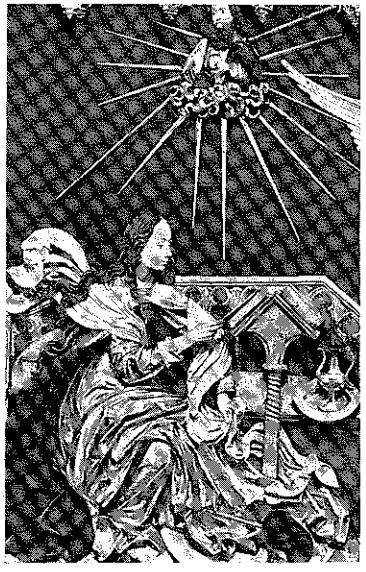
The " Enlightenment " was a period of intellectual history comprised of several " shifts " of thought in various fields of study:

theology, philosophy, physics and — for our purposes — ethics. These shifts in perspective were actually *reversals* of what were previously held "presumptions." We can begin with the theological shift. The Renaissance had put a great deal of emphasis on the human person. The emergent anthropocentrism (given impetus from the Medieval fissioning of faith and reason)[7] produced an optimistic enthusiasm about human potential and dignity. This is the Renaissance humanism we know from history. We know that the Protestant Reformation was largely a reaction to this. The darker emphases of the Reformers were intended to restate the absolute sovereignty of God over the affairs of this world. The Renaissance optimism eventually led to the reversal of the previously understood relationship of God and humanity. Thereafter, it was the human creature who stood sinful and accused, without excuse before the Thrice-Holy God. With the Enlightenment, it is God who comes, hat in hand, to justify Himself before humanity. It was God who had to do the explaining, not ourselves.

Next, there was the "Copernican Revolution" in philosophy with Immanuel Kant. He changed "the definition of truth from 'the conformity of our minds to reality' to 'the conformity of reality to our minds'."[8] The summit of philosophy was no longer metaphysics, but epistemology. And this meant that science was equated with physics. For Kant, the existence of God was a practical necessity, but was theoretically impossible to know. The alleged noumenal reality of God would have no phenomenal aspect, and therefore is forever beyond the reach of knowledge. The reversal in philosophy, then, consists in this: formerly, philosophy was concerned with being, with reality. With Descartes and Kant, its subject matter is the mind. Metaphysics is replaced by epistemology. Human knowledge establishes the conditions for reality itself. "Truth" is relegated to the "subjective," not the "objective" side of reality.

This reversal becomes more understandable in the nineteenth century. At the beginning of that century, another development of this form of anthropocentrism north of the Alps was the theoretical atheism of the Young Hegelians, most notably Feuerbach. In his thought, theology is reduced to anthropology. The realization that "God" is the name for humanity's idealized self is key to overcoming the alienation inherent in religion. It is in this way that humankind's faith in itself, its power and its future are recovered.

Interestingly, it is John Courtney Murray's contention that atheism has its origin not in rational argument, but in moral outrage.[9] The existence of an almighty, loving God is incompatible with the poverty, disease and sadness of the world we experience. "If there were an omnipotent God, He would have had to create something better than this." Nietsche takes this to its nihilistic extreme. Kant plus Feuerbach yields either Marx and Freud, on the one hand, or Nietzsche, on the other. This corresponds to John Courtney Murray's thesis that there are two types of atheists in the post-modern era: the man of the communist world revolution and the godless man of the theatre (theatre of the absurd).[10]



In case you asked yourself whether the Copernican Revolution in philosophy does not presuppose a Copernican Revolution in science, I would say, "Logically, yes; actually, not necessarily." The real shift is at least symbolized by Charles Darwin. His theory of evolution "showed that the origin and development of [the human race] was simply a phase of cosmic evolution in general, that [humanity's] higher activities could be adequately explained in terms of this evolution, and that at no point was it necessary to introduce the notion of creative activity by a supramundane Being. The fact that there is no necessary connection between the scientific hypothesis of biological evolution and philosophical materialism was indeed clear to some minds at the time. But there were many people who either welcomed or attacked the hypothesis, as the case might be, because they thought that materialism was the natural conclusion to draw from it."[11]

The "reversal" in science occurred this way: previously, it was believed that the order of the universe was a reflection of an underlying harmonious substrate. It can be said that pre-Socratic philosophy is essentially (not entirely) cosmology. That is, it is largely an attempt to understand nature. Even the premier evolutionist, Anaximander, posits the existence of an indeterminate primary element more basic than the opposites which come to be and pass away. In other words, classical cosmology presumed "cosmos." In classical thought, it was humanity that introduced the element of chaos. From its pre-Socratic beginnings to its Renaissance apex, order and harmony were the presuppositions of philosophy and science.

Darwin marks, at least symbolically, a reversal of this presumption. Evolution progresses by the negative feedback of cruelty and competition for survival among species. Cosmos comes from

chaos. The notion of "survival of the fittest" and material evolution, combined with the other reversals in theology and philosophy, set the intellectual stage for the idea that order emerges out of chaos in an evolutionary way. Even physics suffers in this view. In physics, order emerged from amorphous matter and the universe "runs down" by spending its energy in expansion. Today, theories of entropy and randomness dove-tail with Big-Bang and Big-Crunch cosmological theories. Physics is no longer predictive, but only descriptive.[12] The reversal, then, is this: classically, cosmos is primary, chaos is derivate. Now, chaos is primordial and cosmos evolves out of it.

Anthropology becomes the study of a very sophisticated accident. The goal, point or *telos* of human existence is not given by scientific research, because, in fact, such a *telos* or meaning of life does not exist. Rather, humanity itself becomes the instrument, the *faciendus* of its own creative energy. In other words, since there is no *inherent* meaning in being human, meaning must be imposed by a design of the "project of existence."

To summarize, then: There have been shifts of focus which characterize "modern" thought as a whole. There has been a move from theology to anthropology; from metaphysics to epistemology; from creation to chaos and predictive to descriptive science, therefore from physics to mathematics.

All this has a profound effect on ethical theory. It has been the "disquieting suggestion" of certain quarters of philosophy that moral language in the contemporary sphere is actually the linguistic rubble left after complete intellectual catastrophe.[13] In its basic structure, ethics is the study and science of getting from where and what we are, to where and what we ought to be, by doing what we ought to do. The catastrophe is what I have just outlined. The reversal in the theological perspective (with its resultant atheism) leaves us without a *terminus ad quem*. That is, it leaves us bereft of a "final cause" so we must make our own. The reversal in science leaves us without a coherent *terminus a quo* or starting point in nature. There is no real "nature" of the human being, but rather a study of emergence and change with only the broadest descriptive, not predictive, outline of order. In fact, the evolutionary order or the development of species runs contrary to the entropy of the universe and its fall into disorder and unpredictability.

Therefore, without a substantive nature and without a rational purpose or end, ethical discourse — which traditionally guides us from the former to the latter — becomes radically meaningless. The ethical endeavor becomes politics in the most jaded sense: accomodation by social contract. This, I suppose, is the "organized stalemate" of the modern pluralistic State. Without a fairly clear point of departure and point of arrival, ethical discourse is a bridge suspended in mid-air coming from nowhere, going nowhere and collapsing into the silence of the underlying abyss.[14]

Moral Theory in the Fallout: Proportionalism

The intellectual heirs of post-Enlightenment moral theory have been numerous. Not all have borne the most handsome fruit. Particularly thorny in this regard is the development and use of proportionalism in Catholic moral theory. We all know that a great deal of theological energy has been devoted to moral methodology since *Humanae Vitae*. The limits of time and topic do not permit an examination of this, but methodology is crucial for moral theology. In fact, any question about a practical moral problem is really a question about the adequacy of method.

The manifold problems of proportionalism are dealt with elsewhere, but I would want to say a few words about it that tie in with the reversals that have occurred during the Enlightenment.

First, theories of proportionalism (European or American) are based on an elaboration of the distinction between person and nature. The *locus classicus* of this in twentieth century theology is in Karl Rahner's essay on "Concupiscence."[15] Here, the late Jesuist theologian describes the personal aspect as that from which free decision about oneself arises. The aspect of nature is undestood to include all that is given prior to free decision. Nature is the material about which the personal aspect "decides." It is that which is determined, while the personal aspect is that which determines. Nature is the chaotic, inertial matter given meaning or purpose by our creative intellects. Matter is purely instrumental, not inherently meaningful. The operative "virtue" becomes efficiency. Since there is no inherent meaning, it cannot harbor the possibility of moral absolutes. Nature cannot imply moral absolutes because morality pertains only to reason, or, in this case, "intention." Rahner and others of this school are criticized for denegrating the role of grace. I think that a stronger case can be made for the opinion that it is "nature" which has lost its meaning.

Be that as it may, in moral theology, this can be spelled out as a distinction between the transcendental and categorical, the person and nature, or the distinction between the ontic (pre-moral) and the moral. Acts are the "fitful expression" of one's personal aspect. Categorical acts belong to the realm of the "right" and "wrong," the personal dimension is the domain of "good" and "evil." The moral enterprise in this schema, that is, the judgment of the good or the evil, is a determination of whether or not this "fitful expression" is an adequate expression of the inmost self. This is a dualism that severs the connection between good and evil, and right and wrong.

Human acts become instruments by which one brings about a certain state of affairs. Because they are evaluated on the basis of efficiency, not on the basis of inherent meaning, there may be "virtually exceptionless moral norms," but none can be "actually exceptionless." Logically speaking, doing something that is "wrong" is not the contrary of "good," but is the contrary of "effectively expressive."[16] This is a reversal of what was held in former times.

Stepping back into the secular currents of thought we were discussing earlier, in case we think that Descartes, Hobbes, Darwin, Kant et al. have no contemporary application, let me make one observation. We Americans are obsessed by two things: sex and death. A recent study made by a leading women's group found that in a given television season (mid-September through March), the major networks make 14,000 references to sex. Another study a few years ago found that by the time the average child receives a driver's license, he or she has witnessed 16,000 deaths on television, apart from the news. If these figures do not constitute an obsession, then obsessions do not exist. The two — sex and death — are related, and deeply. My point is this: another reversal has taken place at the level of everyday life. In the Christian worldview, we have been conceived by a deliberate act of love and die because of some anatomical accident. Today, in the secular worldview, the exact opposite is proposed as normative: We are conceived by accident and we die by a deliberate act ...either of hatred or of a cruel mercy.

Pivotal Consideration

This highly selective scan of the modern non-Catholic intellectual milieu hopefully outlines the dimensions of the gap to be bridged in Church/world dialogue. In order to effect any bridge building, good foundations must be laid on each side of the expanse. Beyond Scripture — that is, beyond positive revelation — there are three pivotal considerations or presuppositions to Catholic moral theology — medical or otherwise: the theory of the natural law, the competence of the Church as authoritative teacher and the notion of conscience.

Individual thinkers work their way from the self-evident first principles of the natural law to the level of explicit concrete norms in a variety of ways. Despite their individual differences, though, these scholars all agree that natural law theory is the "tradition of reason." In light of the reversals that consitute secularism, we claim that the intelligibility of things is the grounding of all human knowledge. Factual statements are understood to be true or false. Ethical statements are understood in this way too. A great deal of work is being done to revitalize or reimplement natural law theory as a common language shared by all the participants in contemporary ethical conversation.

This natural law can be known by human reason and is a participation of the rational creature in the "eternal law," which itself is essentially the very reason and will — or essence — of God Himself. God directs all creatures to their fulfillment in accord with their natures. Now, the human person is created to the image of God (*Gen* 1), which image consists precisely in the capacity of "self-determination" through one's own reason and will. Consequently, humans are not led passively to their fulfillment but co-author that in a historical process with God by the moral decisions they make. In this light, one must then understand that human freedom or the capacity of self-determination is *not* the possibility of constant revision along some indefinite temporal continuum, but is rather the faculty by which we establish ourselves in a definitive and eternally valid way to *be* — and to be of a certain moral character. Precisely by these decisions, we incarnate ourselves as certain kinds of beings. It is precisely in this that the seriousness of morality consists, as well as the seriousness of evangelization.

Further, the Church teaches both faith and morals. While the phrase "mores Ecclesiae catholicae" has a broader extension than the current word "moral," there is nevertheless undeniably an ethical component to the Church's authoritative teaching. (It is, parenthetically, this desired aspect of wholesomeness that plays a considerable role in rendering all of the Church's teachings "authoritative" without the need to be "authoritarian"). The "Magisterium" finds expression in the teaching of the hierarchy — the bishops in union with the pope. This is also the role of tradition, which Chesterton understood to be a very "liberal" concept: "democracy spread out through time." That is, as political democracies do not distriminate against people by accident of their birth, tradition does not discriminate against them by accident of their death. Tradition, magisterially taught, then, is the articulation of collective wisdom brought to bear on an issue of the day.

Also, conscience plays a large role in this overall understanding of morality though traditionally it has been understood as little more than a dictate of practical reason declaring that a particular action is right or wrong. More recently, the notion of conscience has been further impoverished by locating it within the unholy alliance of authority and dissent. The authority model of conscience results in an inadequate understanding of the nature of conscience. True, it does *judge* actions to be of a certain moral quality and it is through conscientious decisions that we assume a particular moral identity. But conscience is *not* creative of the moral good. Conscience is a capacity of prudent application. "Conscience is an organ, not an oracle."[17] As an organ, it is perceptive, not creative.

In their pastoral letter on conscience, the Bishops of Ireland compared conscience to the human eye. The eye does not create the order of the world around it, but perceives it and allows one to act on the knowledge acquired by it. In the same way, conscience acquires knowledge from its proper surroundings: from revelation (mediated by Church teaching), from community experience and from its particular situation. Like all organs, conscience is perfected by practice. There is a developmental aspect to conscience which has a psychological aspect (in terms of its formal structure) and also a theological aspect (in terms of its actual, specific formation, i.e., the content of values and norms according to which it makes its judgements.)

The Discipline Takes Shape

Let us return to the precise field of medical ethics. We have thus far taken a brief look at some of the pivotal presuppositions of gen-

eral moral theology, the historical backdrop of the Church's concern for medically related questions arising from a fundamental concern for the sick, on the one hand, and sacramental understanding, on the other, and, finally, the notion that answers do not often come fully articulated in revelation but depend on human reason. At this point, let us see how these factors converged in the history of the Church to form this discipline which is in large measure her offspring

The writings of the Church Fathers from the earliest " layer " of Catholic writings — predated only by the Canon of Scripture (with the possible exception of the writings attributed to John.) These writings contain the homilies, scripture commentaries and written prayers of bishops and theologians up to about the seventh and eighth centuries. One of the earliest such writings, the *Didache*, or the Teaching of the Twelve Apostles, dates from about the year 90 and contains the first explicit condemnation of abortion in Christian literature. This teaching, along with many others, was repeated by every major Father and is an often quoted text in our own day. As mentioned earlier, private confession in the form we have it developed in the sixth century. As an aid to priests, *Libri Paenitentiales* were developed and widely used from the sixth to the eleventh century, containing a detailed catalogue of sins and their appropriate penance.[18] This dovetailed with the development of Canon Law in the twelfth century, which dealt in part with the sacramental/moral/medical concerns mentioned earlier. In the fifteenth century, however, the first work dealing precisely with the duties of physicians appeared from the pen of St. Antoninus, the Archbishop of Florence († 1459) In the third volume of his four volume " summa " of theology, he outlined the duties and obligations of various people: married couples, virgins, widows, rulers, soldiers, lawyers, doctors, merchants, judges, craftsmen, etc. Concerning doctors, he insisted upon their competence, diligence, and care for patients. They have the obligations of informing the patient of his condition and to prepare them for death He has the right to receive a just fee, but must also treat those unable to pay St. Antoninus believed that physicians should be paid by the State rather than by individual patients.[19] And doctors should never prescribe anything against the moral law, such as fornication or abortion. The Archbishop was the most frequently quoted source until the time of St Alphonsus Liguori, the patron saint of moral theologians († 1789). In the nineteenth and twentieth centuries, hundreds of titles appeared from the Catholic press to be used in Catholic medical and nursing schools.

Contemporary Issues

Today we, too, have the obligation to put the words with the music in the medical-moral arena The questions are often very complicated and the social forum is much less tolerant of Christianity Nevertheless, today the Catholic Church is the single largest health care provider in the world. Even in the United States, nearly twenty percent of all patients in acute care facilities are being treated in Catholic institutions.

The essentially medical ethical issues almost always involve high technology, " therapeutic " or experimental The moral question behind many of the issues is there-

fore often the same: May we morally do everything we are technologically capable of doing? Life sustaining procedures lead the thoughtful person to ask " at what point we stop prolonging life and start prolonging death? Why do palliative or comfort (only) care patients so often die in acute care facilities? Are we treating diseases or patients? Aside from accidents and major surgery, why do people die in ICU's at all? " Turning to the future, and the blossoming field of genetic research, what must we consider in the possible restructuring of the human person? What reasons do we give to support our " No " to fertilization intervention — A.I. and IVF? How do we reasonably respond to experimentation that has no relation to personal therapy: the possibility of cloning, cyborgs, and chimeras?

Internally, there is much discussion today about the identity of Catholic health care in the United States. The image of Catholic Health care for us has traditionally been the Religious Sister. However, in the past 20 years, almost 70% of the women religious in primary patient care are gone.[20] They no longer exist. And neither does the image. From the historical perspective, that fact should *not* be disconcerting The example of Christ's concern for the sick has taken many forms

The question of the Catholic identity of our hospitals is not so much a matter of the Crucifix over the bed or the bishop's picture in the lobby or whether or not a nun takes your blood pressure. Catholic identity is a matter of values, not artifacts. Catholic values embrace and employ many artifacts, it is true Catholic identity is not a disembodied spirit. Essential to this is corporate membership which guards and assures the Catholic identity of a particular facility.

Further, we cannot conscience immoral procedures such as abortions or contraceptive sterilizations on our premises We must respect the lives of everyone, from the recently conceived to the all but dead. Those who enter our doors must experience something different from a " community hospital. " They must experience our conviction that " charity " demands that no one be beyond the limits of our concern and compassion. To encounter a Catholic health facility must be an encounter with the healing touch of our Master, who said, " What you do to the least of My own, that you do to Me. " And in the absence of the Louise de Marillac's, the Camillus de Lellis's et al in the vows of religion, we return to our roots and look to the contemporary counterparts of Saints Fabiola, Paula, Elizabeth of Hungary: the laity to continue to leaven our world with their holiness

The anwer to many ethical questions remains obscure — if not jolting. The Catholic tradition, however, is still in the making and we must approach that future with hope — the forgotten virtue — as well as faith and love Your children will be called upon to answer questions we cannot even formulate. But by our conviction that Christianity can respond with *humane* answers to human problems, we have every reason to believe that we can win a hearing among the reasonable.

Our role in this as educators, Catholic health care providers and thinkers is capsulized by St. Paul in his second epistle to the Corinthians: " Every thought is our prisoner, captured to be brought into obedience to Christ " (II *Cor.* 10:5) Fidelity to the word of God and the teaching of the Church has been the single, underlying constant in all successful enterprises. Faith is the gift of Christ to His followers Faith inspired the compassion of the caregivers of every age: in the deacons and laity of the patristic age, in the bishops of the Roman empire, in the monks of the early medieval period, in the mendicants of the high middle ages, and the religious of the Counter-Reformation and modern periods. Today, Mother Theresa says: God calls us, not to be successful, but to be faithful. The contagious attraction of fidelity will inspire men and women in this post-modern, secular age to continue the tradition which we have no reason to be ashamed of. We need alert and concerned bishops because it is for this task that at least some people must be educated: those who appreciate the tradition, who are conversant with the present realities, who are articulate with the facts and who have the mental capacity to think, to dream, and to respond for the Church in creative fidelity — in short, men and women who can put the words with the music for our time and for the building of the future.

The Rev. RUSSELL E SMITH, S.T.D.
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[1] This thesis holds true despite the recent historical studies such as Martin E. Marty and Kenneth L. Vaux, eds. *Health/Medicine and the Faith Traditions*. Crossroads, New York. 1986-87. Particularly pertinent in this series would be David M. Feldman, *Health and Medicine in the Jewish Tradition* [1986], which does mention the writings of the rabbis throughout the ages regarding certain topics such as abortion, etc. Also interesting in this series in Fazlur Rahman, *Health and Medicine in the Islamic Tradition* [1987], who credits Christians (particularly of the Nestorian heresy) with providing medical personnel and the translation of medical texts from Greek into Syriac [p. 66].

[2] James P. Cassidy, " Ethics Committees: Relationship to the Local Bishop, " in Russell E. Smith, ed., *Critical Issues in Contemporary Health Care*. The Pope John Center, Boston 1989, p. 140f.

[3] Unpublished paper on Medical Ethics given to the New England Chapter of the Catholic Health Association [NECCHA] by James O'Donohoe, October, 1988.

[4] *CIC* 1917 c. 139 2.

[5] Charles E. Curran, " Roman Catholic Medical Ethics, " in his *Transition and Tradition in Moral Theology*, University of Notre Dame, 1979, pp. 176ff

[6] Pope John Paul II, " Sono lieto, " [Apr. 10, 1986] quoted in *The Pope Speaks*, vol. 31, no. 2 [1986] p. 178. Also, see *Redemptor Hominis*, 10, quoted in *The Pope Speaks*, vol 24, no. 2, [1979], p. 110

[7] John Courtney Murray, *The Problem of God*, Yale University, 1964, p. 90.

[8] Benedict Ashley, *Theologies of the Body. Humanistic and Christian* The Pope John Center, Boston 1985, p. 641

[9] Murray, *op. cit.*, p. 101

[10] *Ibid*, pp. 104-110.

[11] Frederick Copleston, *A History of Philosophy: Modern Philosophy. Schopenhauer to Nietsche*, vol. 7, part II. Image Books, New York 1963, pp. 127-28.

[12] Cfr. Ashley, *op. cit*, pp. 38-42 and p. 49, footnote 51.

[13] Alasdair MacIntyre, *After Virtue*, Notre Dame, 1981

[14] *Ibid*, pp. 52-59.

[15] Karl Rahner, " The Theological Concept of Concupiscentia " in *Theological Investigations*, vol. 1: *God, Christ, Mary and Grace* Darton, Longman and Todd, Ltd London, 1961. See especially footnote 2, pp. 362-63. See also the equally foundational " Concerning the Relationship between Nature and Grace " in the same volume, pp. 297-317. [This volume is a translation of *Schriften Zur Theologie*, I, published by Verlagsanstaldt Benziger & Co., A.G., Einsiedeln-Zürich-Köln, 1954.]

[16] Russel E. Smith, *The Theology of Sin and its Distinctions in the United States from 1965 to 1985*. Dissertatio ad doctoratum in theologia morali consequendum, Pontificia Università Lateranense, Accademia Alfonsiana, Rome, 1987, pp. 138-39 and 356.

[17] Joseph Ratzinger, " Bishops, Theologians, and Morality, " in *Moral Theology Today. Certitudes and Doubts*, The Pope John Center, 1984, p. 14. Cf. R. Spaemann, *Moralische Grundbegriffe*, München 1982

[18] Curran, *op. cit*, p. 179.

[19] *Ibid*, p. 181

[20] Cassidy, *op. cit.*, p. 143

Testimony

The Pastoral Care of the Sick in Colombia

Home Study Program for Pastoral Care

Pastoral Care in Ponce

Report on the Church's Role in the Pastoral Care of the Sick (Comores)

Pastoral Experiences among AIDS Patients

Health Personnel Training Center

Church and Health Care System in India

The Pastoral Care of the Sick in Colombia

Work in the health field has been one of the major concerns of the Church throughout her history And for the Colombian Church this concern for those who suffer has been no less marked.

For the past four centuries we have seen how religious communities become present, bearing Christ's message to the world of suffering, founding hospitals and different types of facilities to care for those afflicted by various illnesses. We thus arrive at the current period, in which different kinds of institutions have multiplied in seeking to respond to the needs of contemporary man.

Faithful to its history, on examining this reality and evaluating needs and the responses required, the Colombian Bishops, meeting in a Plenary Assembly in July 1984, entrusted to the Episcopal Commission for Social Ministry the task of stimulating and strengthening the Pastoral Care of the Sick in the country. It was then that the national Secretariat for the Social Ministry, as the Commission's executive organ, took on this assignment by organizing two programs at the outset:

— Child Survival and Development, supported by UNICEF;

— The First National Seminar on the Pastoral Care of the Sick, attended by parish priests, chaplains, religious, and health professionals from all over the country.

As a result of the National Seminar, a Manual for Pastoral Care in the Health Field was drafted on a provisional basis; after a long process of reflection and evaluation by all sectors of the Church, it is being revised to conform to the demands of real life. This will be the fundamental guide to enlighten and orient pastoral care in health throughout the country.

In the face of the warm reception of its initial action, the Bishops' Commission for Social Ministry decided to create an office within the National Secretariat for Social Ministry which would take on the coordination and activation of the Pastoral Care of the Sick, beginning in 1987

In this way the organization existing today was made possible:

1) a national coordinating body, charged with promoting and counseling the organization of programs which will respond to real needs;

2) diocesan coordination in each ecclesiastical jurisdiction (at this time such coordination exists in 40 of the country's 38 jurisdictions), which on a local level is responsible for promoting, counseling, and organizing programs;

3) a large group of parish workers who carry out concrete work in their communities

This type of " network " has enabled us to provide more effective and dynamic attention to meet real needs; when it becomes necessary, we are able to respond to specific situations in different regions without there having to be a national problem

Each level carries out ongoing analysis of its area of jurisdiction, thanks to which we have managed to give priority to some problems affecting all the country's communities to a greater or lesser degree, on the basis of which we have determined the fundamental programs for the Pastoral Care of the Sick.

— Firstly, Evangelization and Humanization of the world of health constitute the backbone of all efforts. All action undertaken flows from them This program also has its own activities, which at the moment may be summarized in two areas: the first concerns the *value of life*, from conception to death; the second involves supporting, advising, and stimulating the Catholic Medical Association of Colombia (ACMEC), founded in October 1989 with the approval of the Colombian Bishops' Conference and in the process of becoming affiliated with the International Federation of Catholic Medical Associations (FIAMC).

— The second program organized is the Pastoral Care of Senior Citizens. Colombia is a country with a growing population of elderly people, who are beginning to be rejected by their families, above all in the large cities, because they are regarded as a burden. Our actions aim to reincorporate these people into their families and communities, rescuing their value as a " memory of history " and as useful members of a society requiring the wealth of their experience in all fields.

— Another problem area which we regard as important for our intervention is that of the sensorially-physically-mentally handicapped As a result of malnutrition occasioned by poverty, people (both children and adults) whose development has been affected and who require special attention enabling them to approach normal levels and give their best are frequently encountered.

At present we are supporting and promoting the organization of programs (lectures and workshops) within communities themselves — with their participation and that of the families of the handicapped — on the whole process of rehabilitation.

The persons cared for in this way remain emotionally linked to their environment, which welcomes them and allows them to develop themselves productively in accordance with their individual capacities

— The problem of AIDS, though in Colombia not yet so serious as in other countries, falls within our priorities, since it exists and is rapidly increasing. Our work in this field has been focused on giving preference to prevention through education, especially with high-risk groups. Nevertheless, we do not neglect the care of people affected by the virus through family and community education concerning acceptance of and attention to these patients.

— We are organizing a Pastoral Care in Hospitals program for the purpose of evangelizing and humanizing patient care.

All of these programs we have briefly described have required a long process of reflection and study regarding both real situations and the Church's doctrine. For each of these areas we are completing training programs on the three levels comprising the aforementioned network (national, diocesan, parish); and so that our work will be more effective, we act to coordinate it constantly with governmental and private institutions — both national and international — as judged appropriate.

Finally, it is quite important to mention two factors without which our work would become very difficult:

— Firstly, we receive the permanent support of the Bishop's Commission for Social Ministry, to which the Bishop responsible for the Pastoral Care of the Sick in our country belongs.

— Secondly, the teamwork carried out alongside those responsible for the other areas pertaining to the National Secretariat for Social Ministry (SNPS), marked by mutual support and enrichment, has led us to speak of Integral Pastoral Care in the social field

Home Study Program for Pastoral Care in Health in Latin America

In Latin America the pastoral care of the sick has expanded in recent years. Each Bishops' Conference has now organized its Secretariat or Section for this ministry, and in various countries national meetings are held which bring together different pastoral workers from the dioceses and hospitals. CELAM also held its first Meeting on "Church and Health in Latin America," where it was seen to be necessary and important to go on training new workers who can carry forward the varied programs required for the evangelization of the world of suffering and health care.

For over three years, the Hospitaller Order of St. John of God — through the Latin American Interprovincial Secretariat (SAL. OH) — has been devoting a good part of its energies to offering systematic and integral training for those already working or wishing to work in the service of the privileged members of the Body of Christ: the ill. This involves an Extension Training Program to prepare "experts" in the Pastoral Care of the Sick in the main areas required to develop it properly: knowledge of the facts, biblical and theological grounding, ethics, and pastoral guidelines.

Objectives

This program aims to "train pastoral workers in health care methodologically, socially, doctrinally, and pastorally so that they can provide effective service in their communities, representing a living witness of the Good Samaritan at the dawn of the Third Millenium."

This objective is approached in three modules enabling students to

— identify the elements defining the social situation in Latin America so that, in applying them to local and regional analyses, they may orient themselves and others towards a Gospel commitment in the face of the reality they encounter;

— analyze and use adequately the theological-doctrinal principles of the pastoral care of the sick, so that they will be capable of deeper reflection and orientation involving the foundations for this pastoral care;

— recognize the stages and processes which come into play in the pastoral care of the sick to allow them to handle methodologies and technical, pastoral, and psychological instruments adequately in the service of patients.

Curriculum

The student enrolled in this Home Study Program registers to receive the materials needed, com-

mitting himself to following a personal study schedule, taking written tests, and insofar as possible, coming for follow-up interviews

The Program lasts for three years (six semesters), with the Home Study framework. Each year the student studies a subject in depth (a module) oriented by lessons and units designed to permit personalized study, review, exercises, and investigation where the student works or resides. After every two or three study units, the student must take a written test (multiple choice), to be sent to Program Headquarters in Bogota.

Module I

— Evangelizing in Latin America today
— Latin American lands, men, and peoples
— Culture and cultures in Latin America
— How we live and produce (economy)
— Panorama of health in our countries.
— Those who determine our situation (politics).
— The Church in Latin America.
— Pastoral perspectives and challenges.

Module II

— The anthropological dimensions of suffering.
— The biblical-theological dimension of suffering
— Jesus Christ and human suffering.
— Human suffering in the Magisterium of the Church.
— Human suffering in Church practice
— The ethics of health

Module III

— The Christian community and the patient
— The sacraments in the pastoral care of the sick
— What is the helping relationship with the patient?
— Pastoral care of the sick in the hospital.
— Pastoral care of the sick in the parish.
— How to plan pastoral care in health.
— Society, health, and evangelization on the threshold of the third millenium

In addition, those responsible for the program organize periodic meetings for follow-up and updating in each of the ten countries where active students exist at present.

This year it is hoped that ten students will complete the full program, providing the Hospitaller Order with the satisfaction of giving the Church the first " experts " in the pastoral care of the sick, true agents of evangelization in the world of suffering, trained in Latin America. The first person to attain certification as a pastoral " expert " was Sr. Alba Marina Ospina, H C., after responding correctly on all the exams and preparing her final monograph very successfully, which includes social, theological, and pastoral aspects of the health ministry in her community We congratulate her.

Br. MANUEL MARCO
Director

Country	*Students*	*Auditors**	*Total*
Argentina		18	18
Benin (Africa)	1		1
Bolivia	40	5	45
Brazil	9	2	11
Colombia	284	41	325
Costa Rica	6		6
Cuba	1		1
Chile	3	12	15
Ecuador	32	5	37
Spain	2	3	5
Italy	1	1	2
Mexico	64	30	94
Paraguay	1		1
Peru	35	17	52
Portugal	1		1
Puerto Rico	2		2
Dominican Republic	4		4
Venezuela	20	19	39
TOTALS	506	153	659

* AUDITORS: receive material for the purposes of information rather than study.

Pastoral Care of AIDS Patients in Ponce

The Program of Pastoral Care sponsored by de Diocese of Ponce, Puerto Rico had been functioning for two years at the regional government hospital, when in 1984 the number of AIDS patients there began to increase. The director of the program, Sister Marie Teresa Jensen of the Sisters of St. Joseph of Brentwood, New York, spent nearly a year studying this new pastoral problem. Visiting the patients, offering supportive presence to them and their families, she tried to discern the pastoral needs which are " peculiar " to this illness, and how to best respond to them. As a pastoral counselor, Sister reflected on these experiences with the patients, participated in an 18 hour workshop sponsored by the AIDS Foundation of P.R., took part in a Symposium on the disease in San Juan, and worked closely with doctors and other personnel at the hospital.

The Program of Pastoral Care, in the Mass of Commitment on April 6, 1987 included 80 volunteer pastoral visitors who ministered in the government hospital, in two private hospitals and a Cancer Hospital. In addition, a new group of volunteers, mostly professionals in health care or related professions, was begun, a Home Program of Pastoral Care for patients with AIDS. All 80 volunteer pastoral visitors are certified by the Diocese, having participated in the course of preparation of 20 hours, and supervised practice. The commitment is for a year, and renewed by those who wish each year. The volunteers of the Home Program receive additional orientation by specialists about all aspects of the disease because they are expected to teach, orient, and supervise the home patient. The Home Program volunteer offers emotional and spiritual support of patient and family, always respecting the religion of these persons. In addition, volunteers are taught to evaluate the entire home situation, observing the needs of the " care-giver, " of other members of the family. Attention is given to needs such as patient comforts, need of sheets, medicines, and even for the services of other community agencies. Each volunteer has resources in the office of Pastoral Care and receives help in responding to the needs of the patient. Since each volunteer is responsible for one patient during the entire duration of illness, his/her faithful friendship and availability (even though limited by personal and family responsibilities) has proven very valuable for patient and family.

Volunteers are taught techniques of " auto- therapy " which help deal with the many difficult situations of patients without suffering depression in the " helper ". No volunteer is alone in his/her pastoral work, and Sister Marie is alert to how each volunteer is dealing with personal reactions to patients. The patient needs are many and varied, and we have attempted to alleviate seemingly insurmountable situations: at a patient's request his mother was located after many years to be reconciled with her son before death; another dying patient was afforded the opportunity to speak to 26 drug addicts because he wished to exhort them to abandon the life of drugs; one patient requested instruction and preparation for Baptism which we celebrated with eight other patients in the AIDS ward with great joy and a party. Not long ago a prisoner in the same ward, a real leader, informed the sister that all six of the present patients were ready to celebrate the Sacrament of Reconciliation, (another joy-filled occasion!) He himself had spoken convincingly to his comrades and helped each one. Standing by these patients during the course of the illness, we try to be alert to what is happening emotionally, spiritually, and in relation to the family. Follow-up is offered to the patients at the city jail when they return from the hospital, and of them eagerly await the day of our visit.

Our policy is always a faithful friendship, always offering confidentiality, and unconditionally, as long as our care is requested. No one judges anyone's life style or conduct, even if we cannot always approve of it. Orientation is offered respectfully, and we try to be sensitive to the right moment to challenge a patient when necessary, at times calling him/her to greater faith. The Lord calls us to reach out to our suffering brothers and sisters in love, a love which speaks to the patient of God's love, of his/her own dignity, to which God calls him/her, and the capacity to live Christian life because of the redeeming Gift of Jesus on the Cross.

Since the training of the volunteers includes some skills of psychology which facilitate listening and the discernment of needs, the person of the volunteer becomes a valuable resource for the family going through the different phases of their loved one's illness of AIDS. A monthly communication has been established so that each patient receives some inspirational message from the office of pastoral care. In some cases we find the family of the AIDS patient rejected by neighbors, usually because of fear of the disease. Very discreetly the volunteer deals with the situation, even offering a videotape on the subject of AIDS which educates and orients with the true facts about the illness.

We are aware of many needs where we hope to attend or to direct the family of the patient to the proper agencies. We have many needs in the program which keep us from being more effective. The

volunteers need materials to offer the patients as well as the families, devotional pamphlets, orientation on the Sacraments, on God's forgiveness, posters, cards, and other things to send patients, as well as material which could afford the volunteers some spiritual growth and knowledge At this time the volunteers have little or no resources as to books available to read for self-improvement We are aware that we must pray, count on the light of the Holy Spirit, and be very grateful for the privilege of working together with our Church in Ponce. We can always count on our pastors, our Bishops, and have seen the love with which His Excellency, Bishop Ricardo Surinach visited the patients in the AIDS area, encouraging and blessing each one.

It is the experience of each of the volunteers, as well as of Sister Marie, that in reaching out in love with Christ's message to his suffering people, we receive far more

than we give We are changed; we come to know the Lord ever more.

Without the help of the Extension Socity it is doubtful if any of this work begun in 1982 could ever have been initiated in Ponce, P.R. It is truly an example of service made possible by a Society which empowers groups in the Church to bring the Lord's message to another little spot in the Kingdom!

Report on the Church's Role in the Pastoral Care of the Sick through Caritas-Comores

General Picture of Health Involvement

Independent since 1975, after having been a French colony, the Islamic Federal Republic of the Comores recognizes the right of foreigners living in the country and working in diverse fields to have spiritual guides and to freely practice their religion, in complete respect for Islam, the State religion. The Church, as an institution, is thus the guest of civil and religious (Islamic) authorities, obliged, for this reason, to practice discretion The Church actually carries out two main activities: chaplaincy, for the exclusive use of Catholic foreigners temporarily in the country, on a denominational level, and, secondly, charitable work, mainly in the health field: the latter is the subject of our report

The Church's Charitable Activity in Health Care

In this field, the Church places herself at the service of the country in a spirit of complete unselfishness and in close collaboration with the authorities of the Health Service, according to a protocol agreement signed by both parties.

The two following aspects should be vigorously stressed:

— *Institutions*. The Church (Catholic Mission) runs six dispensaries of varying importance: one in Moroni, the capital, and five others in Brousse (within the country) and on the island of Grand Comore; to these should be added a nutritional rehabilitation center for undernourished children taking in 25 children with their mothers.

— *1987 Statistics*. The statistics, which speak for themselves, show that in 1987 154,253 patients received treatment at the Moroni dispensary, open every day except Sunday, and 62,526 at the other centers in Brousse; this gives us a total of more than 200,000 people who have benefited from our care These statistics are required by the Health Service — global and detailed data according to diseases — and are also of use to us to provide an account to the organisms supporting us medically and financially.

— *Personnel*. The dispensaries, known under the name of Caritas-Comores, are managed by two French religious women who are aided by about twenty assistants of both sexes, Comores natives and Moslems. The physician of the French Embassy, a young man who is completing his national service, attends to the Moroni dispensary very often every week, as does a Canadian for prenatal exams and to train native midwives. A French gynecologist sometimes accompanies the group that goes to Brousse We can thus see that the work of Caritas-Comores is the result of collaboration among religions, races, and peoples This aspect is in itself positive: it draws men together and contributes to understanding and peace among peoples.

— *Human Training*. Professionally, we first try to give our indigenous personnel a chance to complete their training, inviting people to spend trial periods at the Nursing School, whenever possible (this year the Dean came personally to look for a nurse and enroll her in a course), or offering courses ourselves: a woman religious, formerly a teacher in Madagascar, age fifty, went to update her medical knowledge in France, earning a nursing degree before coming to the Camores In addition to this technical competence which we want to give our clinical staff, we want the overall work environment to consist of global education for the best-quality service to the sick and the poor Among the factors fostering this general edu-

cation we observe the following: fidelity to daily work; attention to patients; the organization whereby nothing is lacking throughout the year for patient care; constant concern for cleanliness; good financial management, which allows all, both men and women, to receive a salary at the end of every month; paid leaves, or maternity and paternity leaves; the free work of the Church, which respects the State religion; trips to the seashore or to the forest; video evenings; gatherings with Catholics for a formal toast on the occasion of Epiphany or the Patron's feast day: all of this has contributed to giving our personnel from the Comores a sense of duty, a taste for work, care for the sick, and availability to their fellow men. For our part, we European Catholics have received much from these staff members: the virtue of patience in the face of hardships, joy in adversities, moderation in the goods of this world, and the spirit of mutual assistance On the other hand, in Caritas-Comores we are aware of the fact that our work is, in the final analysis, modest; thank God we are not the only ones caring for the sick; we do our share on a temporary basis Our hope is that, as a result of our small contribution, every patient may feel in the care lavished upon him a heart that loves him I believe I can affirm that our staff in the Comores works in this sense, though the heat is sometimes unbearable and fatigue great on account of the long mornings devoted to care; all our men and women are happy to form part of Caritas-Comores. The Europeans who come to help us are sensitive to the joyful, industrious atmosphere at our dispensaries. Proof of it is found in the tears of a young woman who had to leave us after having worked with us for a whole year; or the young doctor who agreed to make an additional visit each week to the Moroni dispensary during the holidays of the woman religious in charge of it.

— *Moral Formation*. Once a week, during the Friday afternoon meetings, the woman religious in charge of the general formation of nurses has the opportunity to deal with current moral questions spoken of by the mass media. A nurse formed by her repeats this instruction for the young women at the Schools for Homemakers in Brousse The Moroni Homemakers' School has also included moral formation in its programs As regards the doctors outside the service of cooperation, I have not yet found a way to bring them to reflect on these important questions But to the few practicing parishioners I always present the Magisterium's documents concerning these questions at the Mass; in our parish bulletin I make an effort to call the reader's attention to these problems and the Church's teaching. Finally, during catechesis for adults — not more than three or four — I deal with these questions, which they have already heard discussed.

— *Formation of Patients*. At the Nutritional Rehabilitation Center the mothers arriving with their own children receive basic training in hygiene and the care of children which is certainly not insignificant and contributes to bringing them to discover the dignity of the human person. With more numerous and competent personnel we could do much more and do it better. At the dispensaries (both ours and those of the Ministry of Health) patients receive advice on the way to treat and avoid illnesses and must possess the clinical file enabling the evolution of the disease to be followed. In a word, education for hygiene, prophylaxis, maternal and child prevention: this is Caritas' activity, not to mention treatment and vaccination

In concluding, I must point out that our Minister of Health went with one of my friends twice to the Vatican, knows Archbishop Angelini, and is aware of his visit to the Indian Ocean this year

FR. JEAN PEAULT, M E P
Apostolic Pro-Administrator of Comores

Pastoral Experiences among AIDS Patients in Ouagadougou, Burkina Faso

While substituting for the Chaplain at the Public Hospital of Ouagadougou, Burkina Faso, the author worked with patients there and pastorally attended AIDS victims both at home and in the hospital

At the only public hospital in Ouagadougou, the capital of Burkina Faso, in West Africa, AIDS victims are suffering and dying in increasing numbers.

Most of these people condemned to death on account of the human immune deficiency syndrome are young men and women between 18 and 25 years of age and married adults, both men and women, between 30 and 40.

AIDS patients generally come for hospitalization in the manifest stage of the illness. The sick, in our social context, have a tendency to present themselves at the hospital only when their situation has become serious or critical. Quite often they first resort to traditional healers, the witch doctors; in effect, for many people the hospital is a synonym for death, not life — a place of despair, not hope. Among other things, what explains the fact that the sick in our midst wait until the last minute before turning to health facilities is the enormous distance separating them from such centers — in general, few in number and badly equipped — and, above all, a lack of economic means to purchase medicines, systematically prescribed by the doctor or nurse.

It is not unusual to hear the sick or healthy say, " Why go to the hospital? No medicine! No treatment! No prescription! " And this is the sad reality. Many patients suffer and languish because of a lack of medicines and treatments. For one patient, a few ampoules of penicillin would have been needed to save his life; for another, a few ampoules of quinine would have prevented his death by curing malaria. It is true that efforts are being made, but the health situation continues to be alarming.

If I briefly mention this situation in Burkina, I do so to call attention even more to the singular and dramatic condition of AIDS victims in a social environment normally short of effective medical treatments.

The AIDS patients I have assisted pastorally at home and in my country's public hospital experience a special situation due, among other things, to a lack of medicines and means to deal with the illness' complications: clinical manifestations, opportunistic infections, etc.

AIDS victims particularly need our fraternal attention, our constant and faithful moral, psychological, emotional, spiritual, and material support; the personnel charged with care, family, friends, and all of society are seriously called to build up effective solidarity for the persons affected by AIDS. Alongside the AIDS patients hospitalized in Ougadougou or remaining in their homes, there is always the emotional presence of relatives and friends — the phenomenon of isolation and abandonment of persons affected by AIDS does not exist among us. The suffering of these persons is, in a certain sense, shared in and lived through by whoever loves them.

We try to devote special attention to the AIDS victims hospitalized in Ouagadougou or at home and to their families, all of them faced with enormous sufferings, undergone in the expectation of imminent death. The pastoral approach to AIDS patients and their relatives requires competence and knowledge, tact and sensibility, and a capacity for sympathy. In this perspective, we make an effort to establish a pastoral dialogue with both groups of persons, giving priority to an attitude of listening and discernment, to know and understand situations, in order to attempt to offer a word of consolation and hope. With the relatives and friends accompanying patients during the hospital stay we organize community prayer gatherings — for the sick — in the hospital chapel. Charismatic groups from different parishes in the city also come to these prayer meetings.

We try to help poor patients lacking means as far as we can. To this end, the Chaplain responsible for Ougadougou Hospital, my brother in religion, has created the *Pharmacie de la Fraternité* to assist the needy ill. Throughout the world, our brothers and sisters who are ill with AIDS and struggling against death call us to compassion, constructive and operative solidarity, inspired and animated by love, in the manner of the Good Samaritan.

FR. FRANÇOISE SEDGO
Camillian

Health Personnel Training Center in Yaoundé, Cameroon

1. Nature of the Center

The Catholic Missions' Health Personnel Training Center, founded by the Jesus Christ Society, has been recognized by the Ministry of Health as the " Private School for Nurses and Nursing Assistants of Yaoundé. "

This center is a nonprofit work of the Church forming part of the Catholic Health Service.

2. Aims

The Training Center seeks to train and recycle health promoters in the roles of nurses and nursing assistants, with their various specialties (laboratories, gynecology, etc.), necessary for the smooth running of Medical Centers and Hospitals of the Catholic Missions in Cameroon

Depending on the places available, the Training Center can accept candidates from private clinics, company infirmaries, and other organisms, such as the CNPS, etc

3. General Objectives of Training

Personnel training in health care is a pastoral activity which must follow the directives of the Catholic Bishops' Conference of Cameroon, in agreement with the norms issued by the Ministry of Health.

The Training Center seeks to train competent, aware, and responsible personnel capable of focusing its activity according to the spirit of the teaching of the Church and fostering in men and women a sense of responsibility for their human and spiritual development from a personal as well as a family and community standpoint.

Within this spirit study and testing programs must conform to ministry decrees in such a way as to attain at least the technical competence determined by the Ministry of Health.

In accordance with their level, students are to be presented for the competitive exams organized by the Ministry of Health.

4. Specific Objectives of the Training Center

To train medical aids, nurses, and midwives capable of working at the Mission health centers, often far from medical or technically advanced facilities.

Our objectives fit in with the descriptions of the role of each category of personnel found in the Ministry of Health's directives.

The Trained Nurse is destined to direct a Basic Health Center — that is, called to assume responsibility for primary health care in villages, on health committees, with country health workers, etc., in addition to examining and treating patients with ordinary pathologies, while necessarily able to discover the signs of complications in order to resort to a more competent person

The Trained Obstetric Nurse is responsible for pre- and postnatal examinations and for physiologically normal births, with the obligation to turn to someone more competent in the case of an abnormal birth, and responsibility in our missions for education, village nutrition, and organizing and supervising local PMI's.

The Nursing Assistant plays a basic role in primary health care, health education, community development, etc , also selecting elementary treatments within the sphere of the health center for the purposes of general care, while acting under the supervision of the chief nurse The laboratory assistant is capable of carrying out basic analyses needed for a sound diagnosis

N.B.: The reopening of the government's Trained Nurses Section is under study

5. Organization

The Training Center has a broadcasting station in Tokombéré to train nursing assistants in northern Cameroon

In Yaoundé the center possesses Le Foyer residence for young women who, having come from far away, have trouble finding a place to stay in the city Daily life at Le Foyer, which is subject to evolution in its modalities, is recognized to be an integral part of the human and Christian formation the Center seeks to provide.

Theoretical and practical instruction is offered in the School building. Applied exams are conducted for the whole section of Maternity, PMI, and Laboratory; priority is given to maternity and private PMI's of Nkoldongo The other testing is done first in the Health Centers and Hospitals of the Catholic Missions and Ad Lucem and for specialized services at hospitals and public centers.

6. Financial Organization

6.1. Support comes from local contributions representing about 35% of resources and foreign contributions representing about 63% of resources

These contributions are constituted by a grant for operations from the Raoul Follereau Foundations and scholarships from *Misereor*, *Cebemo*, and *Nemisa*.

6.2. It should be observed that *Misereor*, *Cebemo*, and *Nemisa* also grant funds for living expenses amounting to 300,000 F. CFA per year for each of the 120 scholarship recipients

6.3 Donors will continue to help the School to the extent that local participation increases; it must progressively reach 50% and 100% further on.

A project to create a Common Fund sustained by the Catholic Missions' Health Centers is under study.

Health Personnel Training Center of the Catholic Missions, Yaoundé

Healing Church and Health Care System in India

Health and healing have been topics of perennial interest to men and women of all nationalities. Healing has always played a central role in the mission of the Church. This paper is an attempt to examine various health care systems in India and the healing presence of the Church in India.

Although little is known about the health care system of ancient India, archeological excavations indicate that the ancient Indians had a rather high health consciousness: Around 1400 BC India was invaded by the Arians, and the *āyurveda* system of medicine came into existence. The medical systems that are truly of Indian origin and development are the *āyurveda* and *siddha* systems.

Āyurveda is the science of life practised throughout India. It is considered to be the oldest medical science existing in the world. As a "knowledge of life" āyurveda enables the individual to lengthen his earthly existence. It aims at making human existence of a perfect beauty, enabling it to evolve and ultimately, to merge into the divine. In āyurveda it is important to consider the person as a whole and understand his psychosomatic constitution. Treatment in āyurveda is mainly divided into eight branches which include all the methods of treatment, and is grouped into three categories, namely, *kayacikitsa* (general medicine), *salyatantra* (surgery) and *manasikacikitsa* (psychiatry). The Hindu medical system was renowned from antiquity for the lead which it gave to the world, especially in operative surgery and in the richness of its "materia medica." Susruta, the great surgeon, mentions in detail in his medical treatise the need for scrupulous cleanliness of both operation room and instruments, and gives techniques for caesarian section, complicated cranial surgery, amputations, and other dexterous operations of Indian invention. The ancient Indian physicians were also pioneers in the use of anaesthetics, medical vines and powders being recommended to produce insensibility to pain. More than seven hundred medicinal plants are mentioned by Susruta, who himself administered them in various sicknesses. Thus, the ancient Indian medicine has a unique place in the world.

The reasons for the rise and subsequent decline of Indian medical science and the care of the sick are to be traced to the religious and philosophical concepts which Hinduism has developed and which strongly influenced the Indian attitude to suffering and the ideas held by Hindu physicians of the cause and treatment of disease.

In common with all other medical systems of ancient civilization, the earliest Indian medical practice was largely magical in character. Many diseases were considered to be prompted by the malevolent spirits. But during the Brahmanical period (800-50 BC) we note a profound change in the beliefs and practice of religion and medicine. The practice of medicine by priest-physicians became a characteristic of Indian medicine during this period. At the same time it has caused tragic caste distinctions. As the caste system hardened, several unhygienic habits and superstitious practices began to be imposed by the dead weight of traditionalism. The philosophical speculation which accompanied the development of Brahmanism led to a new conception of God and the universe, which in turn has influenced the decline and stagnation of medical practice.

The rise and development of Buddhism had a great influence on

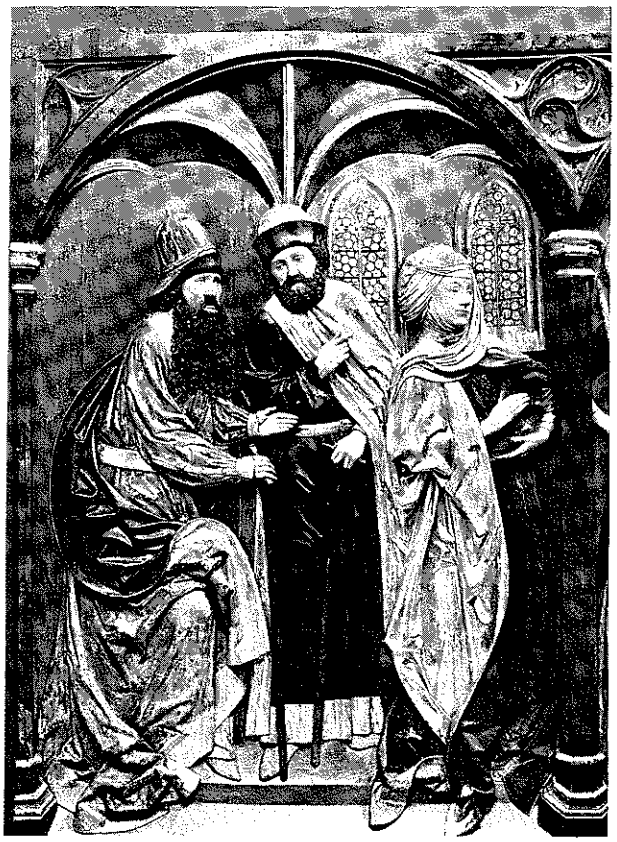
Indian medical practice. This period (500 BC - 200 AD) coincides with the most fruitful period of Indian medicine The practice of surgery could not make progress, as Buddhism would not permit the dissection of animals and the human body But the other branches of medicine made a notable advance under its humanitarian influence The humane spirit of Buddhism, with its tolerance and practical kindness, inspired the organized care of the sick and suffering The *ahimsa* commandment (commandment not to kill or harm any living creature) was not meant to remain merely in theory. But with the decline of Buddhist influence in India and the re-establishment of Brahmanism, Buddhist hospitals disappeared.

The Moslem invasion and conquest of India in the eighth century AD was another factor contributing to the decline of Indian medicine. The invaders had brought along with them their own physicians and introduced a medical system known as " Unani-Tibb, " whose origin is to be traced to ancient Greek medicine The Arabs developed it into an elaborate medical system, giving it a scientific base. This system reached its apogee between 800 and 1300 AD and enjoyed the support of the rulers till the advent of the British In the course of time, the ayurvedic and Unani-Tibb systems influenced one another.

Siddha is another indigenous medical system which has very much in common with āyurveda. Siddha *vaidyam* (medical practice) is an esoteric skill, a tradition of healing practice which is transmitted orally from teacher to student generation after generation on the basis of selective procedures of which the outsiders know practically nothing. According to the siddhas, man has a five-fold *deha* (body), the triune natural body and a double supernatural body. The natural body is formed of impure matter and hence it has to be purified, transmuted and transfigured, and made eternally into one with life. Siddhas also believed in the law of transmigration Death, according to them, is only the rejection of the old form, and one slips into the transmigratory process. The goal of every siddha is to attain *mukti* (release, salvation). Like the medical system they have mastered, this also remains a *rahasya* (secret) Even today there are siddhas who practise in South India.

Though not of ancient and Indian origin, homeopathy is also considered to be an indigenous medical system It came to the west coast of India in 1834 through the Basel missionaries and later to Bengal through some German geologists. Though homeopathy is practised in several countries, India claims to have the largest number of practitioners of this system in the world.

The modern health care system in India is the " Western " type allopathic system, which was introduced in southwestern India by the Portuguese in the early 16th century and was spread through the country by the doctors of the East India Company (17th century) and the European missionaries. Before the dawn of the 19th century itself allopathy hospitals were established in the major cities of Calcutta, Bombay, and Madras. The British government adopted an indifferent attitude towards the indigenous " nonscientific " and " nonmodern " systems of medicine. Gradually all support was withdrawn from the indigenous medical system. The emphasis of the colonial health policy was on the



establishment of urban, curative hospitals. The leaders of the independent India extended the British model of health care service in India instead of making a radical change in health policy so that the basic health care needs of the masses could be adequately fulfilled.

Only slightly over a hundred years ago the Church in India began to focus her attention on the health care needs of the people and started several health care institutions The Catholic Church and Protestant churches have a well organized medical care system in India. They carry out their healing apostolate through institutional and noninstitutional means, medical and nonmedical maintenance. Most of the institutions are related to the Christian Medical Association of India (CMAI), Catholic Hospital Association of India (CHAI), or Voluntary Health Association of India (VHAI).

The Catholic Church alone has more than 3000 health care institutions all over the country. They include hospitals, dispensaries, leprosaria, homes for the elderly and disabled, orphanages, and centres for human promotion. In order to train the health personnel, there is a well established medical college (St. John's Medical College, Bangalore), over a hundred nurses' training institutes and paramedical institutes The Protestant churches have two medical colleges, several nursing schools, hospitals and many health centres and community health programmes Outreach centres — ambulatory care, health education, and family planning — are also the concern of the Indian Church. There is also the Church cooperation at different levels with the government of India to promote the health of the people CHAI, Catholic Nurses' Guild, Catholic Doctors' Guild, and Natural Family Planning Association of India are national organizations of the Catholic Church directly involved in the health care services. The volume of work done by the Church is enormous. The service rendered by the Church is far ahead of other private and voluntary agencies.

In spite of various mentionable achievements in the field of health care, to which the Church in India has contributed her share, the health care system in India continues to suffer from several deficiencies. Many eradicable diseases, like Tetanus, Polio, Goitre, Tuberculosis, Leprosy, Blindness, Guinea Worm, etc. are still prevalent in the country. There are serious locational and qualitative imbalances in the services rendered to the various sectors of population. To a large extent, the present health care services are patterned on the Western type of curative medicine The approach is sickness oriented rather than person oriented. Preventive, promotional, rehabilitative, social, educational, and spiritual dimensions of medicine are almost neglected. Indigenous medicines do not get due recognition in the present system. Many health professionals, with their " Western " type of medical training, are alienated from the common man and turn out to be a superior class and make health care an " industry "

The limits and inadequacies of the existing health care services demand a rethinking and renewal of the Church's apostolate of healing in India The healing Church is called to face new challenges. She should reorient health care activities, giving priorities to the pressing needs and health problems of the masses. An ongoing and ethical formation of the healers and health personnel should become part of this educational programme We need a healthy environment for a healthy life The healing Church should awaken an ecological consciousness among the people through education and witness.

The emergence of community-based primary health care centres is a positive sign Of late there is also a reawakening in the Indian Church of the nonmedical approach to the ministry of healing. Prayer, charismatic renewal, and inner healing, counselling and pastoral care, etc. are some of the nonmedical means which promote health, healing, and wholeness in the Church, hospitals, and communities.

The healing Church in India is summoned to a united Christian witness. A spirit of ecumenism and Christian love enable the Church authorities to venture into united efforts of healing mission. They may also go beyond the ecumenical approach and work in collaboration and cooperation with other voluntary health associations, irrespective of the caste and creed they belong to. The Church's healing presence becomes a reality in India when her precious and valuable health-giving powers are properly channelled to promote the physical, psychological, social, and spiritual well-being of persons and communities

THOMAS SEBASTIAN
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O.F.M. Capuchins

Activity of the Pontifical Council

Addresses

Chronicles of Meetings

The Priest Is Called to Take the Savior's Sympathy to the Sick

Remarks by Archbishop Fiorenzo Angelini, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, at the Eighth Assembly of the Synod of Bishops, October 8, 1990

1) While noting that the *Instrumentum Laboris* of this Synod (paragraphs 2, 3, 21, 45, 47, and 56) has taken into account some of the suggestions previously made by the Pontifical Council for Pastoral Assistance to Health Care Workers,[1] I feel that the precise theological notion of the health care ministry and the importance and urgency of its being included particularly in the formation of candidates for the priesthood and the continuing education of the clergy are only vaguely expressed therein.

2) Numerous statements by the Magisterium of the Church — not cited, moreover, in the *Notae* to the *Instrumentum Laboris*[2] — indicate that the health apostolate — that is, operative and spiritual solicitude for those suffering — is "an integral part of the Church's mission."[3] John Paul II, in his teaching and ministry, has affirmed in varied forms that "man is the way of the Church"[4] and that he is such *especially* when tried by suffering.[5] He has also stated that "in the loving and generous welcoming of every human life, particularly if weak or ill, the Church today is living out a fundamental moment of her mission."[6] Indeed, "in the Redeemer's concern for the sick," the Holy Father has confirmed, "the Church sees the example providing a norm for her own conduct."[7]

3) Pastoral care, then, without the health component is deficient, for it is deprived of the charism to which Jesus, the physician of souls and bodies, gave priority in his redeeming and healing action. The theological confirmation is rigorous. If Christ, to effect salvation, took on the condition of the least ones, suffering to the point of death on the Cross, the priest, as continuator of Christ's work, is duty-bound, by vocation, to meet mankind where Christ approached it — that is, in suffering. This, and no other, is the way of salvation.

4) With respect to the role the health ministry should play in priestly formation, the entire address delivered by John Paul II at the *Angelus* of Sunday, August 12 proves enlightening, referring explicitly and directly to the Synod. "Among the tasks of the priestly ministry," the Holy Father said, "is that of visiting the sick, which brings them moral, spiritual comfort to help them bear the trial of illness and overcome it. With a view towards the next Synod, we also wish to reflect briefly on the formation aimed at making priests capable of carrying out this task."[8] And he added, "The priest is called to follow the example of Christ and to take all the Savior's sympathy to the sick,"[9] recognizing in them "the presence of Christ...in the perspective of salvation."[10]

5) I hope that no one will be tempted to regard these assertions — particularly because of the theological truth they contain — as conventional or mannered, almost as if they were not really norms applicable to the most serious problems of the vocation crisis, of the *ratio studiorum*, or, in any event, of the human, cultural, theological, and spiritual formation of aspirants to the priesthood.

I feel, on the contrary, that the dangerous and superficial appraisal of the health ministry basically derives from a triple mistake, which may be formulated as follows: it is not true, as is presumed, that all priests carry out the health ministry or spiritual care of the sick — indeed, our sick brothers in the priesthood are too often forgotten; it is not true that all who carry it out are able to do so adequately; it is not true that implementing this aspect of overall pastoral care is something easy.

6) It is not true that all priests carry out the health ministry. There are regions and dioceses, even in countries with a Catholic majority, where many hospital and care facilities entirely or almost entirely lack the presence of priests and men and women religious. It is, in fact, symptomatic and sad that among the first places to feel the negative effects of the drop in vocations have been precisely hospitals, when, on the contrary, they should have been regarded as a priority for the Church's pastoral care.

7) It is not true, moreover, that all who carry out the health ministry know how to do so or that it is an easy task to perform with no preparation and practical training. In the different stages of their programs, many seminaries overlook the health ministry, which is also omitted from the curricula of a number of Catholic universities, academies, and theological faculties. From the years of seminary training on, special courses should be offered by experts on service to the sick, with exercises in practical ministry — including active participation in the administration of the Sacraments of the Sick, catechistical and liturgical activity, moral and nursing assistance, and other forms proper to lay volunteers. For young men aspiring to the priesthood, such experience becomes an effective school for life, reinforces them in spiritual values, and helps them to confirm themselves in the vocation received and accepted. The health ministry is likewise an extraordinary means of providing the priesthood — reached and exercised in a way closely analogous to Christ's — with human and ascetical support.

8) The creation in Rome of the Camillianum Pastoral Institute to grant academic degrees in the pastoral theology of health care and the fact that at the Lateran Pontifical University the course on the health ministry has, beginning this year, acquired juridical stability as a permanent offering in the general program of that University's Pastoral Institute by virtue of a special fund established *in perpetuum* by the Pontifical Council for Pastoral Assistance to Health Care Workers are indicative of the line

to be followed. Analogous initiatives should enter into national plans for vocations and the pastoral programing of dioceses.[11]

9) Let it not be forgotten that the hospital is the largest and most frequently visited temple in the world and that the ill make up the vastest church assembly. Illness and suffering are the only door to which all human creatures without exception throng. Christ cannot be the only one to receive man on the threshold, but we priests must as well, and all who aspire to continue Jesus' healing mission in the priesthood. People must be formed for this mission, not in a general sense, but with rigor and specific training. As regards this subject, it is not enough for us to meet — we must be united.

Allow me to warmly greet all Bishops, priests, and the ill around the world. They are spiritually in our midst in this Synod Hall. Their apostolate of suffering in body and spirit is certainly a forceful invocation of Christ, the Eternal Priest, *ut mittat operarios in messem suam*

[1] SYNODUS EPISCOPORUM. VIII Coetus Ceneralis Ordinarius. *De Sacerdotibus Formandis in Hodiernis Adiunctis Instrumentum Laboris* (Vatican City, 1990). It is asserted therein that the right to health is among the basic human rights (par. 2); that the Church is interpellated by the drug phenomenon, other forms of alienation, the questions posed by bioethics as regards care of the handicapped and the terminally ill, and the progress achieved by science and technology in the fields of biogenetics, gene manipulation, and nuclear energy (par. 3); and that priestly spirituality involves a deep commitment to embrace the example of Christ, who " went about doing good and healing everyone " (par. 21). It is noted that the health ministry has taken on new dimensions requiring adequate preparation and formation (par. 45), a formation which implies interdisciplinary knowledge and practical pastoral training (par. 47). It is affirmed that the health ministry must also be the object of the ongoing formation of the clergy (par. 56).

[2] *Ibid.*, pp. 124-125.

[3] Motu Proprio *Dolentium Hominum* (Feb. 11, 1985), 1.

[4] Encyclical Letter *Redemptor Hominis*, 10; cf. 14.

[5] Apostolic Letter *Salvifici Doloris* (Feb. 11, 1984), 3.

[6] Apostolic Exhortation *Christifideles Laici*, 38.

[7] Words addressed to patients and personnel at Sant'Anna di Ferrara Hospital (Sept. 23, 1990). Cf. *L'Osservatore Romano* (Sept. 24-25, 1990).

[8] Cf. *L'Osservatore Romano* (Aug. 13-14, 1990).

[9] *Ibid.*

[10] *Ibid.*

[11] Some proposals in this regard were advanced and discussed in the course of the First Plenary Assembly of the Pontifical Council for Pastoral Assistance to Health Care Workers (Feb. 9-11, 1990). Cf. PONTIFICIUM CONSILIUM DE APOSTOLATU PRO VALETUDINIS ADMINISTRIS *Generalis Conventus Acta*, pro manuscripto, Romae 1990, pp. 46-50.

The Ethical Formation of Health Professionals

The text read by the Most Rev. Boutros Gemayel, head of the Delegation of the Holy See at the Fourth Conference of European Ministers of Health in Nicosia, Cyprus, October 18-19, 1990

I am grateful for the opportunity offered me to present — though briefly — the Catholic Church's thought on the ethical formation of health workers and to confirm the Holy See's will to collaborate constructively in the study and solution of the many serious problems — of both an ethical and a moral nature — posed by the numerous achievements of science and technology in the field of health policy and care.

The Catholic Church, since its origin and over the course of centuries, has regarded the problems of health policy and care as possessing the maximum importance and has reserved a priority position for them in her action. For this reason the Church's experience, matured through her health-care institutions, constitutes a precious patrimony recognized by all I feel it is opportune, then, as a preamble, to clear the field of two prejudices.

In the first place, the Church's posture in the face of the most serious problems posed in the sphere of medical research, science, and practice does not consist of a series of negations, but views these problems in an attitude of constructive cooperation, even when doing so with respect for certain unrenounceable moral principles.

Secondly, the Catholic Church — as shown by numerous documents and initiatives — has paid and always pays the greatest attention to having the immutable lines of nature respected as regards the origin of life and its quality, from conception to its natural close Indeed, the Church recognizes in natural laws the divine design oriented towards leading the whole man and all men to conditions of physical, psychic, and spiritual health which will elevate human nature and satisfy its deepest and most authentic demands.

This premise justifies and reinforces two elements which I regard as fundamental: the need for health workers at all levels — from the most eminent researcher to volunteer and administrative personnel — to have ethical training, a need which is all the more urgent because we are in a society which, while becoming increasingly interdependent, at the same time knows and respects a plurality of cultures, ideologies, political systems, etc. In the second place, it ought to be possible to find a meeting place regarding some common points since if we were to renounce them, it would not be possible to speak of health ethics or the ethical formation of health workers.

The need for health workers at all levels to have basic ethical formation which is constantly updated requires no proof — it is self-evident.

Medicine is undergoing a providential and growing socialization; this situation places those responsible for health policy and care up against problems implying the taking of positions of prime importance — and not just this, but within them there is a whole scale of values which must necessarily find a reference point. Medicine approaches man when he finds himself in a condition of maximum need; for this reason it is necessary for the health worker to possess a human preparation which will make him capable of integrating his professionalism and the contribution of sensibility, of a spirit of solidarity and participation, in addition to the fact that all of us, actually or potentially, are in need and recipients of the aid medicine and medical care can offer.

The need and urgency of this ethical formation become more evident, however, if we consider the underlying elements which must be the object of this formation. Now, medicine arose, has developed, and has meaning as a service to man, to the whole man and all men. Medicine is for life and its quality. And not this alone, but it defends and fosters the essential moments of life.

The consequence is that the presupposition, the core, of the ethical training of the health professional is the acceptance of the principle affirming that human life and the dignity of the human person are values to which any other value must be subjected No medical research, licit experiment, or valid achievement can entail the instrumentalization of life and the human person

One of the most surprising aspects of our time is constituted by certain jarring contradictions: whereas, on the one hand, science is reducing infant mortality to minimal percentages, the laws of a good many nations around the world legitimize deliberately induced abortion, on the other; whereas we go so far as to practice therapeutical obstinacy — sometimes desperately — to ward off the individual's death to the maximum degree, the legal introduction of euthanasia is defended; whereas everyone goes all out to prevent AIDS, an attempt is made to justify the marginalization of those already condemned to this illness

The Church, through the faith guiding her, also recognizes a constructive value in suffering. Though she can comprehend the difficulty in accepting such an interpretation in this field, she is, however, convinced that it is possible, on the basis of reason and from the most diverse ideological standpoints, to reach a meeting point on the principle of acknowledging the fundamental human right to life, a right from which an initial, immediate conclusion arises: if life is the first of the basic human rights, we cannot speak of the quality of life while assuming its suppression In other words, the first prerogative of the quality of life involves its being lived out, even in conditions of fragility, weakness, and illness. Every criterion of discretion to be introduced into this principle would be devastating, as some recent tragic experiences have demonstrated

The Church offers all her support, then, for the ethical training of health professionals, appealing for this purpose to the basic principles — already implicit in the Hippocratic Oath, which I have recalled.

As regards concrete applications, as in the case of constituting ethics committees, there may exist problems in adapting to different cultures, geographical areas, and religious and cultural traditions. What is important is that we should move together in the acceptance of a common principle: the defense and promotion of life and of the dignity of the human person from conception until natural death. The ethical formation of health professionals should draw inspiration from this principle, above all

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Ethical and Spiritual Values for a Healthy Lifestyle

A talk delivered by Archbishop Fiorenzo Angelini in Leningrad on December 12, 1990 at the International Conference on Healthy Lifestyles, organized by the Ministry of Health and the Leningrad Institute for Advanced Medical Studies.

It is certainly significant that the Catholic Church — which, rigorously faithful to her Founder's mandate, regards physical, psychic, and spiritual health as a primary value, a fundamental human right, and an indispensable condition for the full expression of the human persons's life and dignity — should be reprensented at this International Conference devoted to the topic of healthy lifestyles.

Only a few months have passed since I had the occasion — in this same city and place — to engage in useful meetings which enabled us to observe a notable convergence of views on the subjects of humanity in medicine and suitable ethical training for health workers.

Precisely at this time your country is celebrating its winter holiday, further highlighting the fact that a healthy lifestyle embraces a conception of health which does not view man in his physical reality alone, but in his bodily and spiritual totality — both the former and the latter seen in the context of a culture, traditions, artistic expressions, and aspirations which must spur medical science as well to ask about the relationship it is called to maintain to these values. And it certainly represents a great lesson for all men that in the course of two meetings which have taken place in less than a year between the Holy Father, John Paul II, and the Presidente of the Soviet Union, Michail Gorbachov, there has been a joint call for the values of the spirit.

If today, with growing insistence, the concept of health is associated with that of a healthy lifestyle, it is because it is acknowledged, at least implicitly, that lifestyle goes beyond the strictly medical domain. In turn, however, medicine — be it preventive, diagnostic, therapeutic, or rehabilitative — demands in its practical implementation, the concurrence of factors which together shape what we call lifestyle.

As experience itself indicates, though, the primary value called for is " life " Life constitutes the foundation, the root of every other value — it is meaningless even to speak of human values if they are not reflected in a rigorous commitment to defend and advance life, all life, and the life of each human person.

Medicine is by definition called to serve life. What is meant by " life "?

The Church definitely has a precise conception of human life — a conception not all fully share, but I believe I can affirm that precisely in the concept of life defended by the Church the maximum point for encounters and dialogue is found, for mankind, independently of ideologies, religious faiths, social conditions, and cultural traditions, is unanimous about loving life and seeking its defense and advancement.

I have found confirmation of this truth over many years devoted to the pastoral care of the sick. Especially since taking on responsibility for the Pontifical Council for Pastoral Assistance to Health Care Workers, I have had first-hand experience of the fact that no other sphere of encounter is so open and available for the Church herself as is the realm of the topics and problems of health policy and care.

As has, moreover, been stated in a recent Vatican document (Congregation for the Doctrine of the Faith, *Instruction Concerning Respect for Human Life at Its Origin and the Dignity of Procreation*, February 22, 1987, no. 2), neutrality for scientific research and its applications cannot be claimed — and not only this, but the guiding criteria cannot be gleaned from mere technical efficiency, the usefulness provided for some to the detriment of others, or, even worse, from dominant ideologies.

Science and technology, in medicine as well, demand respect for certain basic ethical criteria, the first of which is respect for life, its defense and advancement, from its origin to its harmonious growth and natural close.

Two important conclusions follow from this presupposition which the Christian tradition and the Catholic Church regard as normative for attitudes.

The first is that the ethical principle of full and indiscriminate defense of life does not lessen the freedom of scientific research. On the contrary, as John Paul II recalled a few weeks ago, in the course of the Fifth International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers, devoted to the subject of " The Human Mind, " science, as both research and application, finds an additional motive for expanding its field of activity in an elevated vision of life.

But I would like to say more. Our age, perhaps for the first time in man's history, is patently demonstrating that if science and technology are not guided by precise ethical criteria — the first among which is the defense and advancement of life — they may escape the very control of man, who is their author.

The second conclusion is no less important than the first: man, whatever his physical or spiritual condition may be, can never be used as an instrument for a service which is aimed at man. It is superfluous to recall the aberrations to which every form of instrumentalizing human life may lead. And I feel everyone agrees about the nobility and relevance of the insight formulated by John Paul II in a recent document where he affirms that the Church, for her part, is called to express a fundamental moment of her mission precisely in attention to the weakest and to all who suffer.

The concept of humanity in medicine — that is, of a medical science and practice attentive to man in his unrepeatable personal individuality — is meaningful only if we are called to human values embracing the sphere of the spirit as well.

A healthy lifestyle requires the accepptance of these values and, where they are neglected, forgotten, or combatted, their full recovery. Only by reference to these values does a lifestyle become healthy — that is, ordered towards defending, enriching, transmitting, affirming, and celebrating life.

In any event, may I be allowed a twofold consideration which I see is brought under examination by the very topics of this conference. I am spurred towards this by the experience of so many years spent in the field of health policy and care all over the world.

I am convinced — I could not fail to be — that no aspect of the human condition is so universal or groups us together so much as that which is summarized in the demand for health in its integral meaning. Medical science, then, as both research and practice, is the science closest to man and to the largest number of human persons. It follows that medicine is directly called to become the promoter of a healthy lifestyle, even if by the term " healthy " we mean not only what concerns man's physical condition, but the whole reality of his existence.

No other professional category daily experiences the very close relationship between health and lifestyle, between health and the acceptance and affirmation of certain ethical and spiritual values, as do health care workers.

From this virtually obligatory

awareness there derives a duty that your very own city, with its prestigious Institute of Advanced Medical Studies, bears witness to and promotes. I am referring to the duty of solid ethical and professional training for health workers. If medicine cannot dispense with bioethics, bioethics cannot be separated from medicine.

Without this suitable preparation of health workers, a serious policy to promote a healthy lifestyle cannot be carried forward

Our time witnesses to a contradictory phenomenon. Whereas, on the one hand, the interdisciplinary character of the sciences in general and within the many branches of medicine is asserting itself increasingly, the fragmentation of the disciplines and tasks of health professionals leads to a loss of the necessary vision of the whole. Each health worker may, then, regard the task of training and educating people for a healthy lifestyle as not his own and feel he may delegate it to another. Such is not and cannot be the case

A healthy lifestyle requires a behavioral code which acknowledges certain indispensabile ethical and spiritual values. There may be debate on the most open formulation possible of these values, but not on their consistency and importance.

A series of values refers, however, to a hierarchy within them. Well, then, I am convinced — on the basis of the entire Christian doctrinal tradition and the teaching confirmed vigorously and now daily by the Church — that if at the summit of this scale of values life, in its richest acceptation, is placed, a series of directives will derive therefrom which can muster the broadest consensus.

It is in this spirit that the Church asks for cooperation and offers her own, aware of the fact that the time available for a global commitment to promote a healthy lifestyle is short and does not permit delay.

The Pontifical Office I have the honor to preside over will be close to all the initiatives aimed at fostering awareness and affirmation of a healthy lifestyle, the condition and guaranteee for the full health which is the goal and synthesis of life.

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

Church and Health in the World

A Talk by Fr. José L. Redrado at the Fifteenth National Meeting of Diocesan Delegates for the Health Care Ministry in Spain
Madrid, October 1-4, 1990

I. The Major Realities in the Health Field and the Church's Presence

1. The Field of Health

I shall begin this report with a title and a text which our journal, *Labor Hospitalaria*, published seven years ago:[1] "The Presence of the Sick at the Synod of Bisophs." It was 1983. The Synod was dealing with "Reconciliation." The General of the Order of St. John of God at that time, Fra Pierluigi Marchesi, was appointed an Auditor by the Pope, and in that capacity he attended the Assemblies and prepared an address and document on "Reconciliation in the Health Field." He stated to the Synod Fathers, "We, who, by the mandate of the Church and of our Founders, are alongside the sick, must manifest a feeling of impotence and insignificance concerning what we can offer. It quite often seems that no one is interested in it any longer. For the year 2000 the slogan and program of the World Health Organization is 'health for all'.[2] The utopia of great, unlimited progress dies hard. But it is a fact: the attention of the most responsible men today focuses on the problem of health. Health for all is possible, but reality evidently contradicts the program.

"— 46,000,000 deaths each year.

"— Nearly one billion people are locked into the vicious circle of poverty, malnutrition, and illness.

"— In many areas average life expectancy has not yet reached fifty.

"— In many developing countries the infant mortality rate is between 100 and 200 per thousand.

"— Most deaths registered in a number of developing countries are caused by infections and parasitic diseases.

"— Close to 850 million people live in malaria zones and another 250 million in areas where effective measures to combat the disease have yet to be applied.

"— In tropical Africa alone, a million children die of malaria every year.

"— 200 million people are infected with schistosomiasis.

"I shall not attempt to recall here the tragic imbalances in the distribution of health personnel and hospitals.

"Today, for different reastons, we have a dehumanized medicine.

"A slow hemorrhage has drained the medical and nursing professions as well of the philanthropic ideals which were the pride of Hippocratic medicine.

"Medicine is more efficient, but further removed from man's needs.

"It suffices to recall how people die today: provided with infusions, cannulas, and respirators, but deprived of all friendly contact, without a hand clasping their moribund hand.

"The Church must make herself heard in this cruel, but real framework."

Table 1 which we present below confirm what we have been saying about the health problematic.[3]

Ten years have passed. Health efforts have no doubt been numerous. The strategies previously indicated by WHO have also brought out this will of States, but it is a slow program, as shown by the *1989 WHO Balance Sheet* prepared on tropical diseases. We are still faced by the same figures cited above and the same problems.[4]

2. The Church's Data on Her Presence in the Health Field

Source: *Ecclesiae Insituta Valetudini Fovendae Toto Orbe Terrarum Index*
(E Civitate Vaticana: Pontificia Commissio de Apostolatu pro Valetudinis Administris, 11 Februarii 1986; revised and expanded in 1989).

A) Reading of the data (Table 2)

1) As of June 1989 20,436 health facilities have been identified around the world where the Church is actively present.

2) The Index (Volume I) has thus been enriched with some 9000 new entries in comparison to its first edition (a 79% increase).

3) It should be remembered that the number of health facilities may increase at the conclusion of the survey, since certain dioceses in 22 African countries (55 in all), representing 40% of the continent, have yet to report. Data from some of the thirty-one Central American countries is missing (19%). The same holds for South America; nine of fourteen countries (64%) are absent. As regards Asia, 18 of the 44 countries are missing (41%). In addition, in regard to some dioceses in Europe, data may increase by 17%.

4) 42.2% of the health facilities recorded are located in Europe; 19.4%, in the Americas; 18.9% in Asia; 17.9% in Africa; and the remaining 1.4%, in Oceania. In Europe and the Americas (especially North America), the Church is present for historical, cultural, juridical, and religious reasons. In Asia, Africa, and Oceania motives are basically missionary, charitable, and aid-oriented.

5) Among the health facilities recorded, hospitals make up 34.1%, followed by nursing homes (22.9%, heavily concentrated in the most developed countries), outpatients' departments (20%, heavily concentrated in developing countries), sanatoriums (13.9%), and other facilities amounting to several percent or less than 1%. We should stress the high percentage of outpatients' departments on the continents mainly comprised of developing countries: the vast areas and scattered installations have influenced a preference for primary health facilities, and their simpler organization has favored a more substantial intervention by the Church.

To complement Figure 1 we may also bring out the following facts: through our travels all over the world to familiarize ourselves with the circumstances of the Church's presence and the conditions of need existing in all nations, we found that behind a single word,

Table 1. Health Indicators and Related Socioeconomic Indicators

	Least Advanced Countries	Other Developing Countries	Developed Countries
Number of countries	29	90	37
Total population (millions)	283	3001	1131
Infant mortality rate (per 1000 live births)	160	94	19
Life expectancy (years)	45	60	72
Percentage of babies weighing 2500 g or more at birth	70%	83%	93%
Coverage of the supply of drinkable water	31%	41%	100%
Adult literacy rate	28%	55%	98%
GNP per inhabitant	$ 170	$ 520	$ 6230
Public health expenditures per inhabitant	$ 1 7	$ 6 5	$ 244
Public health expenditures as a percentage of GNP	1.0%	1.2%	3.9%

Note: The figures in the table are weighted means based on data corresponding to 1980 or later years

such as the term " hospital, " for instance, there lie very different realities. In Africa, for example, 86% of these have less than 50 beds, whereas in the United States, 30% of the hospitals have less than 200 beds, and 62% of the total, between 200 and 500 beds.

A reading of our data also informs us of the extraordinary presence of a least 1,100 religious Insitutes working in the health field. In Africa there are 401 religious Orders; in Spanish America, 231; in Asia, 192; in North America, 214; in Europe, 461; and in Oceania, 56. The secular world's calling the Catholic Church one of " the most powerful volunteer associations " on earth is in fact corroborated not only by statistics, but by the evidence of her professional work force assigned to this field of health care, with the priority of coming to the aid of the neediest.

B) The Church's Mission in the Health Sector

The Church exists to evangelize — announce and communicate the Good News — as the continuator that she is of Jesus's words and gestures (*Mt* 28; *EN* 13,14)

" To evangelize is the reason for the Church's existence, and if this is her specific mission, all her members must have a sharp awareness of their own resposibility as regards spreading the Gospel " (the Pope's Message for World Mission Day, Oct. 21, 1990).

" He called together the Twelve and gave them power and authority over the demons and to cure illnesses And he sent them to preach the kingdom of God and restore

Table 2. Overall view of the Church's health facilities

	H	CC	RA	L	RH	CR	DH	A	CO	LB	AD	X
AFRICA	794	725	49	6	50	11	2	1 805	14	77		119
(TOT: 3 652) (17 9%)	(21 7%)	(19 8%)	(1 4%)	(0 2%)	(1 4%)	(0 3%)	(i)	(49 4%)	(0 4%)	(2 1%)		(3 3%)
CENTRAL AMERICA	47	8	26		3	2		67	5	4	3	2
(Tot: 167) (8 5%)	(28%)	(4 8%)	(16%)		(1 8%)	(1 2%)	(40%)	(2 8%)	(2 4%)	(1 8%)	(1 2%)	
SOUTH AMERICA	1 031	77	178	1	18	7		318	18	12		83
(tot: 1.743) (8 5%)	(59 2%)	(4 4%)	(10 3%)	(i)	(1 0%)	(0 4%)		(18 2%)	(1 0%)	(0 7%)		(4 8%)
ASIA	1.352	517	221	11	35	36	1	1.535	2	61		76
(tot: 3 847) (18 9%)	(35 1%)	(13 5%)	(5 7%)	(0 3%)	(0 9%)	(0 9%)	(i)	(40 0%)	(i)	(1 6%)		(2 0%)
EUROPE	2 502	950	3809	131	313	218	7	334	5		299	105
(tot: 8 673) (42.4%)	(28 9%)	(11 0%)	(44 0%)	(1 5%)	(3 6%)	(2 5%)	(0 1%)	(3 8%)	(i)		(3 4%)	(1 2%)
NORTH AMERICA	1 159	452	363	19	7	11		29		1		27
(tot: 2 068) (10 1%)	(56%)	(22%)	(17 5%)	(0 9%)	(0 3%)	(0.5%)		(1.4%)		(0.05%)		(1 3%)
OCEANIA	94	124	52		7	3	1	4				1
(tot: 286) (1 4%)		(32 9%)	(43 5%)	(18 2%)		(2 4%)	(1 0%)	(0 3%)	(1 4%)			(0 3%)
WORLD TOTAL 20.436	6 975	2 853	4 698	168	433	288	11	4 092	44	159	302	413
(100 00%)	*Hospitals*	*Clinics*	*Nursing Homes*	*Long-term Hospitalization*	*Centers for the Disabled*	*Rehabilitation Centers*	*Day Hospitals*	*Outpatients' Departments*	*Consulting Rooms*	*Leprosaria*	*Home Care*	*Unspecified Facilities*
	(34.1%)	(13.9%)	(22.9%)	(0.8%)	(21.1%)	(1.4%)	(0.5%)	(20.0%)	(0.2%)	(0.7%)	(1.4%)	(2.0%)

the sick to health " (*Lk* 9:1; *Mt* 10:1).

" And they left and traveled through the villages evangelizing and curing everywhere (*Lk* 9:6), and they cast out demons and anointed with oil many of the sick and cured them " (*Mt* 6:13)

To the Church, as a community of believers, through the apostolic mandate, has been entrusted the " care of the sick " This task of curing the sick is inseparable from " evangelization. "

The " care of the sick " is included among the Messianic signs (*Lk* 4:18-18; 7:18-23). The life and teaching of Jesus show this union between " the announcement of the Kingdom of God and the liberation from suffering. "

In liberating men from suffering, Jesus opens the way to salvation and concretely initiates the Kingdom of God. The words " teach, " " preach, " and " cure " summarize not only Jesus's " work, " but also the " mode " of carrying out his mission.

The Church's tradition itself teaches us through her Magisterium that

— Service to the sick is an integral part of her mission (*Dolentium Hominum*, n°1)

— The Church seeks an encounter with man, particularly along the path of suffering. " Man is the way of the Church " (*Salvifici Doloris*, n°3)

— Caring for the sick is a *diaconia* of the local and universal Church This ministry is not limited to her faithful, but opens itself — must open itself — out of fidelity to the Gospel, to all who suffer (*Lk* 10:25-37)

— The care of the sick refers to man in his somatic-spiritual unity (*Dolentium Hominum*, n°2)

— It will, therefore, be the obligation of the Christian community to help the sick to free themselves from all that keeps suffering from being " a redemptive force " for them and for others (*Salvifici Doloris*, n°19).

— The care of the sick is a Church *diaconia* which perfectly expresses her essence as a " universal sacrament of salvation " (*Lumen Gentium*, n°1).

We see this pastoral practice with the sick ever alive throughout the Church's history. Sometimes the task involves " substituting, "[5] making her institutions available for service where there is a void— i.e., where the State does not arrive. On other occasions, the Church offers the State, which is already present, " collaboration " as a sign of quality in caring for the sick. But the Church must always carry out her " specific mission of pastoral presence "; as the continuator of Jesus, she is sent to say a word, offer everyone a gesture — particularly, the weak, the elderly, and the sick. It is something unrenounceable — her very mission; the care of the sick on the part of the Church is not a counsel, but a real mandate given by Jesus

To the Church we owe all hospital organization, hotels and hospitals for pilgrims, the sick, and orphans.

Councils and synods — as in the cases of Carthage (309) and Tours (567) — ordered the establishment of inns alongside churches and the obligation to look after the needy, sick people, and widows

St Basil, Bishop of Caesarea of Cappadocia, in about 370 founded a complex called " Basiliades, " representing the creation of an authentic medical facility: hospice, refuge, hospital, and leprosarium.

In that period different types of hospitalization arose:

— The *xenodoquium*, an inn designed to take in pilgrms, travelers, end exiles.

— The *noxocomium*, a hospital for the sick.

— The *orphanotrophium*, to take in children separated from their parents

— The *gerontocomium*, or asylum for the elderly

The fourth century already had all this development in the hospital field.

St Benedict recommended in his rule (chapter 53), " The greatest care should be taken in receiving poor, for in them Christ is received more particularly than in the rich and powerful "

Monastic hospices and the " bell for those who have lost their way " to call disoriented pilgrims wandering through the forest are especially worthy of note.

Saints such as St. Ferdinand, St Louis, King of France, Charles Borromeo, John of God, Camillus De Lellis, and Vincent De Paul; institutions assisting the sick, like the Hospitaller Brothers of St John of God, the Camillian Fathers, the Sisters of Charity, the Little Sisters of the Poor of St. Ann, the Hospital Sisters of the Sacred Heart of Jesus, and others are a living witness within the Church. What richer, more humanitarian, and more convincing apology can human history present than that which centers on the very life of Christ, which the Church continues with her works? No other religion can present deeds speaking with such realism or inspiring love and attraction.[6]

This solicitude of the Church for the sick — witness to which is not only widespread, but grandiose in its quality, as history shows — this concern, I repeat, has been stressed by the Magisterium in recent years. Pius XII illuminated medical science with innumerable discourses forming a text at the present time [7] The Second Vatican Council, aside from the Message addressed to the sick, points out to both the bishop and priests that they should have the greatest solicitude " for the sick and the dying, visiting them and comforting them in the Lord " (*PO* 6,8; *LG* 38)

Canon Law itself (c. 529 § 1) reminds parish priests of the duty to look after the sick and dying and to do so with generous charity

Finally, two documents by the current Pope, John Paul II, *Salvifici Doloris* and *Dolentium Hominum*,[8] the former on the Christian meaning of suffering and the latter representing the Motu Proprio instituting the Pontifical Council for Pastoral Assistence to Health Care Workers, have launched a new movement in the pastoral care of the sick.[9] This pastoral solicitude has also been recalled by the Pope in his Apostolic Exhortation *Christifideles Laici*, nos. 53 and 54.

Without at this point going into a topic which might prove " polemic " — i.e., whether or not the Church should have its own institutions — I am interested in pointing out the great evangelizing and charismatic task the Church is called to perform at health facilities,[10] a task which is proper and peculiar by virtue of her mission, but which in certain historical and sociocultural circumstances she is asked to carry out — to be the voice of those who have no voice When systems degenerate, as happens in many poor countries, people look to the Catholic Church as the only free voice of those without a voice [11]

II. Challenges for the Church in the Health Field

In the first part we have only described some health realities; the complexity is not just in what we have said, but also in other realities which are not our subject at present, but which certainly pose persistent questions for the Church These problems are presented by technical progress under its human and ethical aspects

We shall enumerate some challenges, bearing in mind that each could be the subject of a specific study when viewed from different angles — social, human, ethical, religious, etc.

Main Challenges

1) *Secularization of medicine*, with the consequent loss of spirituality and a capacity for attracting health personnel. The patient is not visited today mainly out of vocation, mission, but for other motives

2) *Dehumanization of medicine*. There is a technical hypertrophy. Man has been displaced by the machine. A technical mentality has been created where the impersonal, stress, and feeling like a robot impede approaching the patient and carrying out integral care. Assistance is becoming increasingly technical and less human.

3) *The lack of ethical preparation* among professionals affects negative criteria in subjects so important for life as genetics, euthanasia, abortion, and death. Or in areas deriving from one's profession: responsibility, respect, justice, and loyalty.

4) *The social importance of health topics*, which often serve as a political platform rather than a solution to concrete facts. Governments and health costs "push" the Church to remain outside. Governments increasingly get into health care as a way to control their people

5) *The complexity of the health field* sometimes makes the distribution of technical, human, and economic resources difficult.

6) *Most of the moral problems* the Church must face today *arise in health care*.

7) *The aging of active religious* in most Institutes, with a consequent withdrawal from professional life [12]

8) *The rapid and deep-seated change* undergone by health care and a lack of adaptation at the same pace and to the same extent by a good many religious Institutes devoted to this field. A qualitative advance is required to meet new health needs

III. Perspectives

The Church is called to respond to these questions and challenges.

1) At a time when the Church's technical-professional presence at health facilities is decreasing for different reasons the world of suffering presents serious moral and spiritual problems which, as we indicated, constitute a challenge for the Church. Although the Church still has to make up for a lack of facilities (in underveloped and developing countries), she is directly called to provide a Gospel response to the questions of an ethical and spiritual order arising from sociomedical organization today and the limit situations of human existence.

2) In the face of the health world's autonomy, which accentuates an estrangement from the ethical and religious order and maintains a "prejudice" concerning man's fundamental values, the Church is called to provide a response to the questions on the meaning of living, suffering, and dying. For that reason, as an "expert in humanity," she must defend man from the multiple violations going against his life and integrity

3) In the face of the culture of death in our time expressed in health policy, the Church must constantly stress the sacredness and dignity of each human person, made in the image and likeness of God, and provide a stimulus so that medical and nursing personnel will make a commitment "not to harm" any human being, any patient.

4) *Coordination*: "Better coordination of all of these organisms is needed. To do so individual action is not enough. An intelligent, programed, constant, and generous global effort is required, not only within each country, but on an international scale. For coordination on a worldwide level could permit a better announcement and a more effective defense of your faith, culture, and Christian commitment in scientific research and the profession" (*Dolentium Hominum*, 4).

5) The health field stands in need of a new evangelization today. John Paul II is continually insisting on this new evengelization on a general level.[13] And it becomes a concrete reality in the health sector, since this field is probably the place of greatest novelty, a bit like a thermometer measuring the profound and accelerated changes occurring in our world, and also the place where new signs are becoming more urgent.

6) This novelty must begin with people — with a change in mentality, a new formation, a new culture. This is a path which will help us to discover the Church's authentic role as a presence in the world of health: "to be witnesses, moral guides, precursors, and innovators, to develop and transform the apostolate."[14]

Fidelity to the Word of God and the teaching of the Church should inspire us today with a new re-

sponse in the health field; and for want of the great champions — John of God, Camillus De Lellis, Vincent De Paul, and others in our century — let us draw inspiration anew from so many of our brothers and sisters, religious and lay, who make their lives an authentic consecration at the service of the needy and in our world and the Church are a sign of gratuitousness, freedom, commitment, originality, generosity, evangelical love, and appealing, creative faithfulness. Or, as a modern author states, " men and women capable of joining the words to the music for our time and for building our future. "[15]

[1] *Labor Hospitalaria*, n° 190 (1983), " Discurso y documento del P Pierluigi Marchesi en el Sinodo de Obispos. "

[2] WHO, " World Strategy of Health for All by the Year 2000 " (Geneva, 1981)

In 1977 the World Health Assembly decided that the main social goal of governments and WHO must consist of attaining for all the world's citizens a degree of health in the year 2000 which would enable them to lead socially and economically productive lives — i.e., what is popularly known as " health for all by the year 2000 " In 1978 the International Conference on Primary Health Care held in Alma-Ata (USSR) declared that primary health care was the key to reaching this goal.

In 1979 the World Health Assembly launched the World Strategy of Health for All on adopting the Alma-Ata Report and Declaration and invited the Member States to undertake individually the formulation of national strategies and collectively the formulation of regional and worldwide strategies.

In 1979 the WHO Executive Council established the fundamental principles for the formulation of strategies for the purpose of attaining health for all in the year 2000

[3] WHO, " World Strategy... "

[4] Cf *Medicina e Missioni*, n°3 (1990), pp 3-17

[5] We find a current concrete example of this substitution in India, where the Church has more than 3,000 health facilities, a university center (St. John's Medical College of Bangalore), more than a hundred centers for the training of nurses and assistants, the Catholic Medical Association of India (CMAI) the Catholic Hospital Association of India (CHAI), and the VHAI, the associations of volunteers in health care.

The work carried out by the Church is enormous. The service provided is much greater than that of private persons (cf. Thomas Sebastian Panachickavayalit, *Healing Presence of the Church*, Bangalore: Good Tidings Publications, 1989, and also " The Church and Health Care in India, " in *Dolentium Hominum*, n° 15/1990)

The same could be said of many countries in Africa and Latin America, where the " specific weight " of the Church in the health field is very significant, in terms of both the number of institutions and the quality of service.

The Church also " collaborates " with the State at a great many health institutions, above all, in some European nations; some of these institutions hold weight to a significant degree with the State network, especially in the areas of marginalization and new needs: the chronically ill, the elderly, and psychiatric patients. Others are instead a sign and reference, a qualitative model in care

Nor can we forget that there is another kind of Church presence in the health field, with the integration of chaplains and women religious into numberless public facilities who, in drawing inspiration from Christian love for the sick, convert their work into a mission and a vocation (cf *Index Ecclesiae Insituta Valetudini Fovendae Toto Orbe Terrarum*, prepared by the Pontifical Council for Pastoral Assistance to Health Care Workers, Vatican City, 1986, and also *Annuarium Statisticum Ecclesiae 1988*, Secretariat of State, Vatican City).

[6] José L. Redrado, *Presencia cristiana en clinicas y hospitales* (Madrid: PPC, 1969). See also Russell E. Smith, " Medical Ethics: A Creature of the Church, " in *Dolentium Hominum*, n°15 (1990)

[7] Fiorenzo Angelini, *Pio XII. Discorsi ai medici* (Rome: Orizzonte Medico, 1959).

[8] John Paul II, Apostolic Letter *Salvifici Doloris* (February 11, 1984), Motu Proprio *Dolentium Hominum* (February 1985), Vatican Polyglot Press.

[9] Fiorenzo Angelini, *Quel soffio sulla creta* (Vatican Polyglot Press, 1990), pp. 162-182.

[10] Javier Oses, *Profetismo e institución en la Iglesia* (Santander: Sal Terrae, 1990) See also *Labor Hospitalaria*, n°188 (1983), a monographic issue on the Catholic hospital, and Fr. Bartolomeo Sorge, S.J., " La Chiesa di fronte alle nuove priorità e alle sfide dell'era tecnologica, " in *Atti Convegno Nazionale Aris-Oda* (Acireale, June 1988).

[11] Cf *Vida Nueva* (August 18/25, 1990), pp 24-30.

[12] Monsignor James Cassidy, " Catholic Hospitals in the World, " in *Dolentium Hominum*, n°14 (1990), pp 22-23. See also Russel E. Smith, *o.c.*

[13] Apostolic Exhortation *Christifideles Laici*, n° 36. Apostolic Letter to the Men and Women Religious of Latin America on the Occasion of the Fifth Centennial of Evangelization, nos. 14, 19, 24, 28.

[14] Pierluigi Marchesi, *Ospitalità dei Fatebenefratelli verso il 2000* (Rome: Curia Generalizia, 1987), pp. 53-58

[15] Russel E. Smith, *o p*

The Gift of Oneself and the Donation of Organs

A Talk by Fr. José L. Redrado, Secretary of the Office, for the Fifth European Bioethics Day, November 30, 1990 (Milano-Medicina 90).

My talk for the Fifth European Bioethics Day, taking place within the framework of Milano-Medicina 90, sponsored by St. Raphael's Hospital, deals, above all, with some of the ethical values which are present in the complex and difficult question of organ transplants.

In willingly accepting the invitation to take part in the session and present a paper, the Pontifical Council for Pastoral Assistance to Health Care Workers has thereby wished to manifest its interest in and appreciation for the Day and the topic on the agenda, in particular.

Archbishop Angelini ardently desired to be here for this day of study, but as a result of urgent commitments, he was forced to present his apologies, while nevertheless guaranteeing the attendance of the Pontifical Council by way of myself, the Secretary. Our President sends a warm greeting to all present here.

The Fifth European Bioethics Day, devoted to "The Ethics of Transplants and Organ Donation," is an important occasion for all of us — doctors, jurists, health care workers, educators — to engage in serious discussion and profound, unanimously shared reflection on a problematic which, though opening up new horizons as regards life expectancy, does not fail to arouse apprehension and suspicion in various respects. On the one hand, the latest successes of organ-transplant medicine, resulting from a commitment and notable effort in varied spheres of the biomedical sciences, have enabled us to save numerous human lives, snatching them from a premature death; on the other, resistance by so many to accepting and opening themselves to the new culture of generosity and solidarity, the authentic establishment of organ-transplant medicine, in addition to a host of questions of an ethical and legal nature, keeps the topic for this study day timely and relevant.

Though I am not, technically speaking, a doctor, I have been given a subject which touches upon the very principle of scientific and medical activity — that is, man: mystery and freedom, capable of self-determination and generous self-donation for the good of others. "The Gift of Oneself and the Donation of Organs," the title of my talk, suggests my dealing with the human, moral, and spiritual foundation without which it not only becomes difficult to make the meaning and value of organ-transplant medicine understandable, but the latter also threatens to appear inhuman and even immoral because it lacks its reason for existence.

The development of the subject takes into consideration two problems, both of which revolve around man, the measure and criterion for transplant medicine.

At the outset I shall speak briefly on transplant medicine as a service to man. Axiological considerations will follow which, in my view, when studied in depth and translated into social education projects, can cause a new cultural awareness to emerge of the eminent value of giving and solidarity.

I. Transplant Medicine at the Service of Man

It is a commonplace to affirm that medicine is at the service of man; a medicine not coinciding "with the true good of man," in the words of John Paul II, threatens to result in "the regression of man" and "dramatic outcomes."[1]

These expressions by the Pope point out clearly the ambivalence of techinical, scientific, and medical progress, which, like a two-edged sword, is not free from risks. The axiom so often confirmed by the Pontifical Magisterium in recent decades — according to which, "not all that is technically feasible is morally and ethically acceptable" — remains valid and timely.

In addressing the field of transplant medicine, I may state that profitable and continuous collaboration between ethics and transplant techniques is an indispensable imperative. Archbishop Angelini rightly asserts this in the following terms: "Cooperation between science and moral philosophy for this reason becomes contructive without ever falling into improper interference, inasmuch as it is unthinkable that for its own progress sicence should demand the sacrifice of the life it is called to serve. Just as unacceptable, however, would be every curb on true progress applied by moral thought — unacceptable because it is immoral and in contradiction with itself."[2]

The complexity and seriousness of the moral and legal problems connected with organ transplants are a stimulus to go forward and take a step in favor of man, his life, and his dignity, in terms of civilization.

The problem of the licitness of organ transplants — arising from the mutual mistrust of transplant medicine and moral thought — after years of suspicion will arrive at a consensus in favor of licitness. The disagreements still existing do not concern the principle of licitness as such, but rather the guarantees as conditions for protecting the values at stake. To accept and maintain the licitness of organ transplants presupposes recognition of the fact that "man is not the 'owner', but the 'usufructuary' of his own body."[3] In other words, man is called as an intelligent and free being to manage and administer his organism in respect for God's design. And even "mutilation," in this context of availability and the responsible management of life, takes on a positive valence inasmuch as life can be reborn therefrom.

Medical judgment, called to evaluate and clarify the different degrees of value in the duty of conserving life and that of conserving bodily integrity, must consider the varied problems relating to the donor, the recipient, and the medical team. Health policy on the national, regional, and local level should also be taken into account. Many other problems of an ethical nature still await clarification and in-depth examination.[4]

In spite of this, while we are awaiting further, definitive elements providing a response, there follow certain points which are regarded us unrenounceable inasmuch as they protect the body, life, and dignity of man like a parapet.

1) "In view of the current situation in transplant medicine, recourse to this particular therapy — given the conditions of willingness and agreement by those involved — must be the only means that can be resorted to — that is, an attempt motivated by the lack of valid alternatives.

2) "In transplants between living persons, the mutilation undergone by the donor must not be such that it places him in the beneficiary's state of need before the transplant is performed."[5]

3) In transplants between a dead and a living person, the donor's

death must be ascertained univocally and medically.

From a strictly ethical standpoint,

4) " The dignity of the human person must be recognized in the case of every being that develops following upon human fertilization, whatever his prospective disabilities and deformities may be, including anencephalia ";

5) " Consequently, all his rights as a man should be recognized, beginning with the primary one, the right to life ";

6) " The extraction of brain tissue from aborted fetuses for the purpose of transplantation is ethically unacceptable ";

7) " Valid ethical considerations also lead to excluding all extraction of organs for the purposes of transplantation from fetuses voluntarily aborted. "[6]

II. Organ Transplants and Ethical Values

A discussion of transplants would be incomplete if the axiological viewpoint were lacking — that is, the values of altruism and solidarity which restore to the act of donation its human-spiritual valence. To give without compensation is what is proper to donation. This generosity becomes heroic in the gift of something belonging to oneself — in this instance, the gift of a part of one's body. In the gift of oneself donation finds the maximum expression of human and Christian altruism and solidarity.

It is true that the difficulties in finding organs to be transplanted do not proceed only from the lack of a culture of generosity in society. There is also the fact that only a few organs are available in the face of the demand among waiting patients. In any event, increased awareness and information on all levels of social life would result in a noteworthy increase in the number of organs available. Among the values to be cultivated and developed, generosity, gratuitousness, altruism, solidarity, and charity deserve special mention.

The notion of " personal identity " remains the key to interpreting every axiological discussion of organ transplants. It transcends the corporeal substrate, opening itself to the other. It is necessary to add the relational dimension, communicability, to personal identity. In writing on this specific topic, Archbishop Angelini states, " Renunciation — and, indeed, sacrifice in favor of one's fellow man — are to be regarded as elements constituting human life and experience. It goes without saying, then, that sacrifice and personal identity are not mutually exclusive, nor can they give rise to conflicting duties. "[7]

Gratuitousness and solidarity are found at the heart of organ donation, which is, in fact, a gratuitous oblation and a visible sign of human solidarity. Concetti says that " organ donation is a sign of the growth of the civilization of love and fraternity. "[8] Even if it seems easy to distinguish beween gratuitousness and solidarity, altruism and charity, in practice all of these values are correlated, enrich one another, and enhance a donor's self-oblation in the act of donating an organ.

The rediscovery of the real, authentic meaning of the gratuitous is one of the challenges our modern civilization faces. In a culture dominated by self-interest and calculation, where man finds it laborious to open himself to another to understand him, become aware of his needs, and help him as a brother, to give without receiving anything in return, as in the case of organ donation, becomes the mandatory path for a civilization seeking to reach the measure of man. Morally, an act of gratitude on the part of the organ recipient — which may be expressed in varied ways, including a simple " thank you " — is equally fitting. A well-known educator of drug addicts states that " gratuitousness in our time is a project, an educational proposal valid for all. "[9] For this reason, every form of trafficking in organs to be transplanted should be rigorously impeded, for " the transplant must necessarily be seen to be connected with an act of donating a good which is unmerchantable. "[10]

Solidarity recognizes in the other a human being with his rights and his equality before all. But, when enlightened by faith, Christian solidarity becomes a synonym for complete gratuitousness.[11] The other is an image of God redeemed by Christ, a temple of the Holy Spirit. This theology of solidarity justifies Maximilian Kolbe's oblation of his life to aid a companion in the concentration camp and the witness of generosity and Christian charity by the Good Samaritan. He is a perfect model for all who wish to do good to whoever is suffering or needy. John Paul II stresses the Good Samaritan's self-giving in these terms: " he puts his heart into it, but does not spare material means either. He may be said to ' give ' himself, his own ' self ', in opening this ' self ' to the other. We here touch one of the key points of all Christian anthropology. Man cannot find him-

self fully except through a sincere gift of himself. The Good Samaritan is precisely the man who is capable of such a self-gift. "[12] In their pastoral documents on organ donation the Spanish Bishops insist on the need to rediscover and cultivate life as a gift of God, human solidarity and Christian charity, and the evangelical attitude.[13] Once these values have been assimilated and lived out, they will bring man to progress morally, opening up new horizons of solidarity and fraternity which go beyond transplant medicine

The religious and fraternal dimension of donation was expressed in these terms to blood and organ donors during the audience held at the Pontifical Palace Castel Gandolfo on August 2, 1984: " In giving blood or an organ of your bodies, always keep this human and religious perspective; may your gesture towards brothers and sisters in need be performed as an offering to the Lord, who has identified himself with all who suffer on account of illness and road or work accidents; may it be a gift made to the suffering Lord, who in his passion gave his whole self and poured forth his blood for our salvation. "

Conclusion

In spite of the complexity of the varied problems, transplant medicine offers mankind new opportunities for human and Christian growth, bringing us to rediscover the lofty values of gratuitousness, oblation, and generosity in the gesture of donation. The words of Cardinal Zoungrana, Archbishop of Ouagadougou, Burkina Faso, wonderfully summarize what is at stake here: " .Man, in his bold research, wants to overcome death, be a bearer of life for his brothers and sisters..., place the energies of his spirit and the resources of his love at the service of life, in homage to the life of the Creator, a Trinity in the one God: Father, Son, and Holy Spirit. "[15]

Organ donation, which is a gesture of gratuitous oblation of oneself, is a way of bearing witness to the Gospel of Christ, who recognizes in the act of giving life to others the greatest sign of Christian love (cf *Jn* 15:13) This love finds its source and its measure in CHRIST; whoever makes a gift of himself in giving an organ experiences and achieves the relevance and timeliness of this Gospel paradox: " Whoever loses life for my sake will save it " (*Lk* 9:24).

[1] JOHN PAUL II, Address to Participants at the Second International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers, *Dolentium Hominum*, n°7 (1988), p. 7.

[2] F. ANGELINI, *Quel soffio sulla creta* (Vatican City: Pontifical Council for Pastoral Assistance to Health Care Workers, 1990), p. 475

[3] *Ibid*., p. 474.

[4] Cfr. L. CICCONE, " I trapianti d'organo: aspetti etici, " *Medicina e Morale*, n°4 (1990).

[5] F. ANGELINI, *op. cit*., p. 476.

[6] L. CICCONE, *op. cit.*, p. 713.

[7] F. ANGELINI, *op. cit.*, p. 476

[8] G. CONCETTI, *I trapianti di organi umani, esigenze morali*, Pimme 1987, p. 69

[9] M. PICCHI, *La vita è una meravigliosa avventura* (Rome: Centro Italiano di Solidarietà, 1986), p. 52.

[10] D. RODRIGUEZ, *Dono, commercio, esproprio di organo, Medicina e Morale*, n°4 (1990), p. 717.

[11] JOHN PAUL II, Encyclical *Sollicitudo Rei Socialis* (December 30, 1987), n°40

[12] JOHN PAUL II, Apostolic Letter *Salvifici Doloris* (February 11, 1984), n°28.

[13] Cf. *Labor Hospitalaria*, n°194 (1984), pp. 238-241

[14] JOHN PAUL II, *L'Osservatore Romano* (August 2, 1984).

[15] P. ZOUNGRANA, " Scienza e fraternità umana " in *Trapianto di cuore e trapianto di cervello* (Rome: Orizzonte Medico, 1983), p. 256 ff

MADRID
(Spain)

Church and Health

Between September 29 and October 4, 1990, the two national meetings of greatest import held each year for those responsible for the pastoral care of the sick in Spain took place in Madrid — the Thirtieth Meeting of the National Team and the Fifteenth National Meeting of Diocesan Delegates. Fr José L. Redrado, Secretary of the Pontifical Council for Pastoral Assistance to Health Care Workers, attended both of them

1. Meeting of the National Team

The National Team for the Health Care Ministry holds two meetings a year devoted to preparing pastoral plans and initiatives which will later be presented through the Bishops' Pastoral Commission to the Spanish Bishops' Conference for its approval and to each and every one of Spain's local Churches to be put into practice. At this meeting, held on September 29 and 30, the following topics were dealt with:

— The initial plans for Patient's Day 1991, which will concern Church and Health and include the analysis of current health models among its tasks, along with contributing a vision and experience of health in a Christian perspective

— The Pastoral Plan of the Health Care Ministry Department for the 1990-1993 triennium, in harmony with that of the Spanish Bishops' Conference for the same period.

— The study of the draft text of a document on the Church and Health in Spain which the Spanish Bishops' Conference will publish in 1993.

— The possible presence and contribution of the Spanish Health Care Ministry at celebrations of the Fifth Centennial of the Discovery of America.

— The programing of National Health Ministry Commissions on Formation, Pastoral Care in Hospitals, Pastoral Care in Parishes, Christian Health Professionals, and Mental Health, along with activities on a national scale for the 1990-1991 year.

— Information on the activities of the Pontifical Council for Pastoral Assistance to Health Care Workers provided by its Secretary, Fr. José Luis Redrado.

The National Team for the Health Care Ministry is constituted by the director and secretary of the National Department, the regional and interdiocesan delegates, those in charge of the five national commissions, and officers of the National Federation of Men and Women Religious in Health Care and the Christian Fraternity of the Sick and Handicapped

2. National Meeting of Diocesan Delegates

With the attendance of more than one hundred participants, between diocesan delegates and collaborators, the Fifteenth National Meeting of Diocesan Delegates for the Health Care Ministry took place in Madrid, October 1-4, 1990.

The first part was devoted to examining the topic of the Church and Health, a task begun with five papers: " Current Health Models: An Approach to the Concept of Health " by Professor Diego Gracia Guillén, who holds the History of Medicine Chair; " The Christological Model of Health: Approaching the Experience of Health in Jesus " by Professor José Antonio Pagola, Vicar General of the Diocese of San Sebastian; " The Human Experience of Health from a Christian Standpoint " by Fr. Francisco Alvarez, Provincial of the Camillians; " The Church, Sacrament of Health " by Mr. Mariano Galve, in charge of the National Mental Health Commission; and " Church and Health in the World " by Fr. José Luis Redrado.

Each of the papers was followed by discussion and reflection in working groups.

As in the meetings of past years, at this one there was also time devoted to exchanging experiences and initiatives among the regional and diocesan delegations, following the guidelines of the Mutual Aid Plan among the delegations promoted by the National Department. This year, in addition, the Department has published a *Dossier on the Diocesan Delegate* in which very useful documentation is offered to organize the functioning of the delegations.

The moments devoted to prayer in common — laudes and the Eucharist, along with the prayer meeting dealing with the Christian experience of health — deserve special mention. They were carefully prepared celebrations which made a deep impression on everyone.

JESUS CONDE HERRANZ
Diocesan Delegate for the Health Care Ministry, Madrid

NICOSIA
(Cyprus)

Fourth European Conference of Ministers of Health

The Fourth European Conference of Health Ministers was held in Nicosia, October 18-19, 1990. The Holy See was represented by an official delegation made up of the Most Rev Boutros Gemayel, Archbishop of Cyprus, head of the delegation; Fr. Maurice Dooley, Professor of Moral Theology; and Fr José L. Redrado, Secretary of the Pontifical Council for Pastoral Assistance to Health Care Workers.

The main topic for the meeting was health personnel in the light of changes and difficulties The Holy See delegation, in its statement to the Assembly of Ministers, dealt with " The Ethical Formation of Health Workers, " the complete text of which appears in this issue of our journal

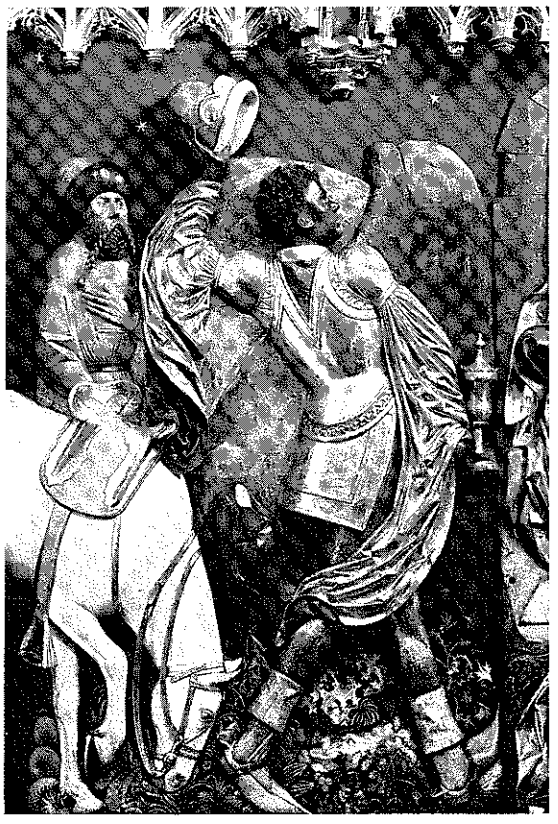
The compact program of these two days also provided an opportunity for various Ministers and delegations to set forth their concerns regarding health personnel, including the rapid decrease in nurses and the need for preparation and updating in keeping with current health needs; demographic topics, new health technologies, new pathologies, and various home care experiences were considered as well

In the open discussion, the head of the Holy See delegation took the floor to stress the need to protect life while adding greater quality to the years — aspects, he stated, which were always present in the addresses of the current Pope, John Paul II, who had also instituted a new Office, the Pontifical Council for Pastoral Assistance to Health Care Workers, for the purpose of stimulating and shedding light on the different facets of the health field

At the conclusion of this Fourth Conference a text was approved stressing the importance of health personnel, formation, the promotion of ethical values, responses to various changes, the management of human resources, new developments in the scientific and technological domains, the social environment of health, and new pathologies These and other points in the final text indicate specific deficiencies and the responses which must be set in motion

Twenty-three nations participated, along with several delegations as " observers ": the Holy See, European WHO, the Council of Europe, etc. If exchanges in the Auditorium were important, so, too, were those in the corridors — it was a chance to multiply experiences

FR JOSÉ L REDRADO, O.H
Secretary of the Office



Cracow, (Poland)

Honorary Doctorate in Medicine for Archbishop Angelini

The Nicolaus Copernicus Academy of Medicine of the Jagellons University in Cracow, one of the oldest in Europe, founded by King Kasimirus in 1364, where Copernicus studied medicine and anatomy, became festively adorned in November.

The center of attention was Archbishop Angelini, who received an honorary doctorate in medicine from this University. There are many factors justifying such a distinction which we could cite, but none so significant as the subject of health, the concern of the new doctor for many years, particularly over the last five in his leadership of this young Office.

Archbishop Angelini was accompanied by the Secretary and Undersecretary of the Pontifical Council, Fr. Redrado and Fr. Ruffini, and a group of Consultors to the Office: Drs. Corrado Manni, Rino Cavalieri, Domenico di Virgilio, and Franco Splendori.

On the 24th, at 10 a.m. sharp, in a serious ambience — distinguished as regards science and culture — the ceremony took place. The Rector of the University, Professor Aleksandr Koj, introduced the event by referring to the curriculum vitae and other factors which had induced the University to grant Archbishop Angelini this degree. The authoritative lecture presented by the new doctor was entitled "The Magisterium of John Paul II for Health Professionals", included in this issue.

Among the Church and government leaders in attendance, we may mention Cardinal Franciszek Marcharsky, Archbishop of Cracow; Most Rev. Jozef Kowalczyk, Apostolic Nuncio in Poland; Most Rev. Bronislaw Drabowsky, Secretary General of the Polish Bishops' Conference; Professor Andrej Kosiniak-Kamysz, Minister of Health; Mr. Vincenzo Manno, Italian Ambassador to Poland; and Professor Tadeusz Cichocki, Rector of the Academy of Medicine.

We should also point out that the Pope's older brother, named Edmund earned a doctorate in medicine at this university, and John Paul II himself received an honorary doctorate there in 1983.

The entire event was undoubtedly an act of recognition of Archbishop Angelini, but, as he himself is accustomed to saying, "It is recognition of the Church, the Pontifical Council, the Pope" for the wonderful work done in the field of health. We would call it a universal recognition, on the same level as the Sasakawa Prize awarded to Archbishop Angelini this year in Geneva by WHO, or the Humanity in Medicine Award bestowed upon him by Gerogetown University in Washington in 1986.

Our stay in Poland offered the occasion for various congratulatory encounters, with the papal representative, Most Rev. Jozef Kowalczyk, Apostolic Nuncio; Cardinal Jozef Glemp, Primate of Poland; the Secretary of the Bishops' Conference, Most Rev. Bronislaw Dabrowsky,; the Archbishop of Cracow, Cardinal Franciszek Marcharsky; and the Italian ambassador to Poland, H.E. Mr. Vincenzo Manno.

On the morning of Sunday, November 25 we visited the Family Institute in Lomianki, near Warsaw, where we celebrated the Eucharist and spoke with the Most Rev. Kazimierz Majdansky, the bishop in charge, and a group of young people on the concerns, projects, and development of this new Institution.

On leaving Poland we can only express our thanks for the sensitivity, recognition, and injection of optimism provided us by this ceremony in Cracow.

J.L.R.

VATICAN CITY

Synod of Bishops

The subject of the 1990 Synod was intensely lived through by our Office, not only during its sessions in the month of October, but also in its preparation, for which we attempted to contribute what was specific to our Department — that is, everything related to health, illness, the sick, and professionals.

The presence of our President, Archbishop Angelini, in the Synod Hall brought us into closer contact with this event by way of several aspects: his statement to the Synod; our Office's publishing the book entitled *The Training of Priests and the Pastoral Care of the Sick*, which was given to every Synod Father; and, additionally, personal and group visits by those attending to our headquarters, an opportunity for us to broaden discussion on this field and deal with concrete facets of the Department.

Fifth International Conference: The Human Mind

For the fifth time the Health Office was responsible for an international meeting, devoted to " The Human Mind, " at the Synod Hall which brought together numerous scientists and experts, November 15-17, 1990.

All scientific aspects related to the human mind were extensively brought out by some sixty researchers and scientists, including several Nobel Prize winners. Theory and practice were combined in magnificent and clear expositions, which dealt with psychiatric, social, ethical, and pastoral dimensions of the topic His Holiness John Paul II closed the Fifth Conference with an address to participants which is a hymn to the human mind, to the greatness of man created in the image and likeness of God, his capacity for mastery over himself and the creation, his freedom, as well as the different limitations, particularly on account of mental illnesses, and he encouraged scientists to study the human being in his totality.

650 people from 90 countries attended. Papers will be published in a monographic issue of our journal *Dolentium Hominum* (n° 16, 1/1991)

THE PONTIFICAL COUNCIL'S PRESENCE AT OTHER ENCOUNTERS

Geneva

On June 27, 1990 an interdenominational meeting took place, organized by the Christian Medical Commission of the World Council of Churches. The topic was " Role of the Churches in Drug Abuse. " Several proposals were made requesting greater intervention by the mass media and religious authorities to combat drugs, avoid traffic, draw up an official text condemning it, and so forth.

The Pontifical Council was represented by Abbé Jean-Pierre Schaller, one of our Consultors.

Rome

— The International Federation of Catholic Pharmacists celebrated its fortieth anniversary in Rome, November 3-4, 1990. More than three hundred professionals participated Archbishop Angelini and Fr. Redrado attended, and the former stressed in his message to participants in the ceremony the ethical responsibility of the Catholic pharmacist. A summary of the events comprising this anniversary celebration is included in this issue.

— On November 13 the academic year was officially inaugurated at the Camillianum. Fr Redrado, Secretary of the Office, presided over the academic session during which doctorates, master's degrees, and several diplomas in the pastoral care of the sick were awarded Fr. Virgilio Pasquetto, Dean of the Teresianum, delivered the main address, on " The Believer Faced with the Experience of Pain " Fr. Cinà, Dean of the Camillianum, introduced the session by pointing out the ground that had been covered during the first four years of academic life. Fr. Redrado thanked those who had obtained the different degrees and invited them to put their knowledge into practice; he also conveyed his best wishes and congratulations to the Camillianum for the seriousness and responsibility of its work.

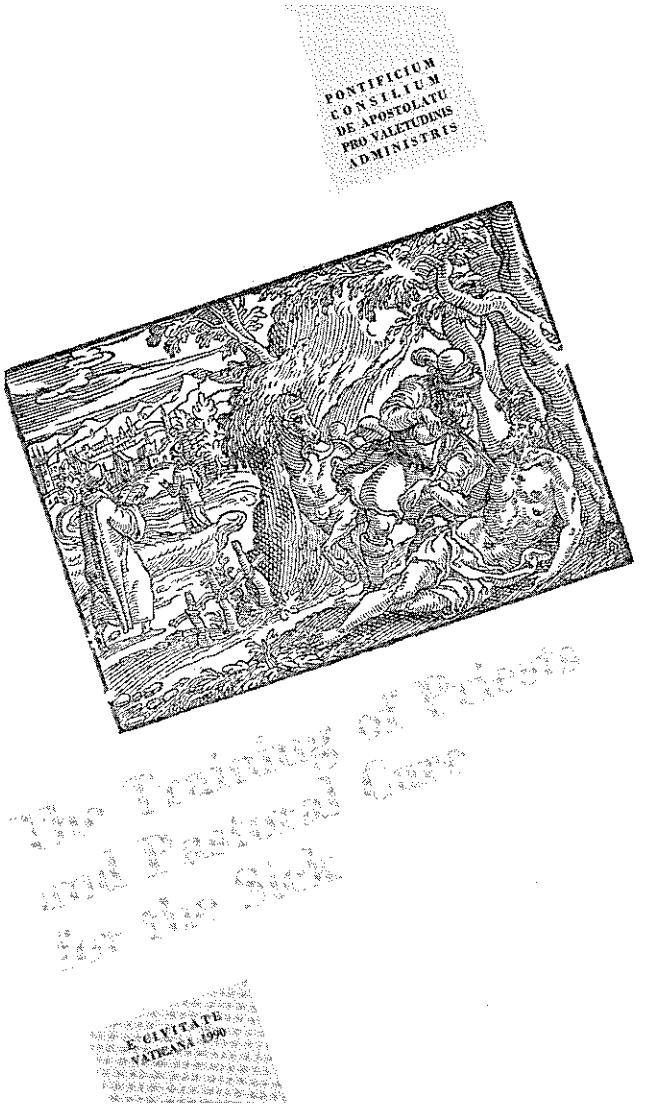
— The Pontifical Council participated, through the presence of Fr. Redrado, in a meeting organized by the Pontifical Council for Promoting Christian Unity held in Rome on December 4. The topic of the meeting was " Reflection on Relations with International Pentecostal Movements "

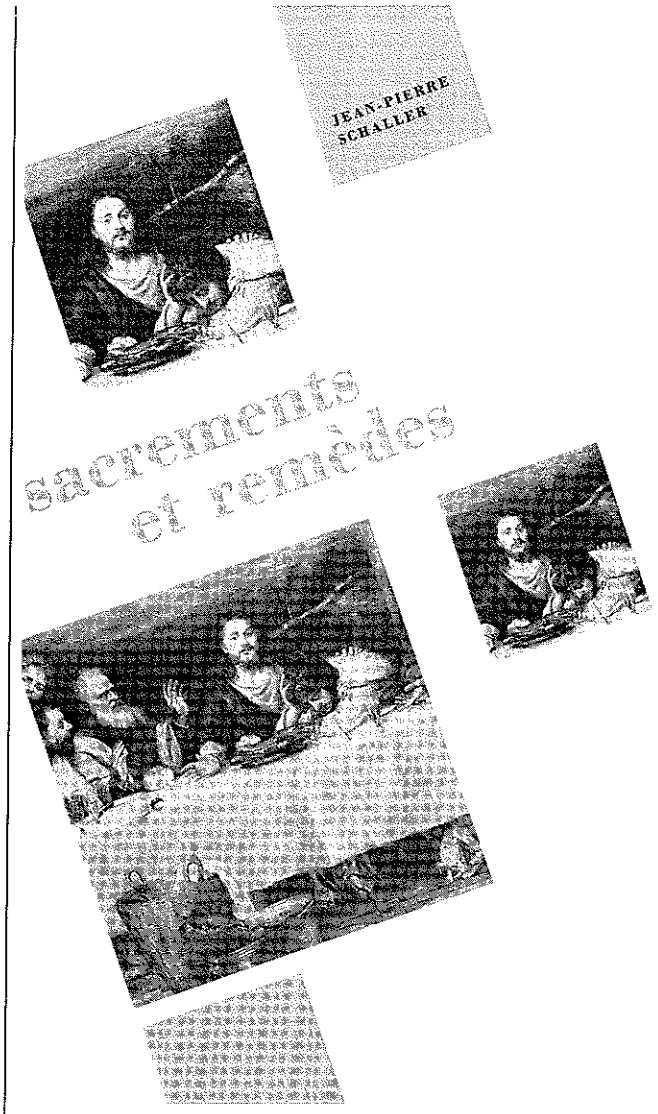
Milan

On November 30, in the framework of Milano-Medicina 90, the Fifth European Bioethics Day was held, devoted to organ transplants

Fr José L. Redrado, Secretary of the Office, participated in the day with a talk on " The Gift of Oneself and Organ Donation, " which is included in this issue of our journal.

Two new documents of our Pastoral Care





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(THAT BREATH UPON THE CLAY)

The volume, divided into three parts
(I Health, II Alongside the Sick,
III Alongside Health Professionals),
represents a systematically arranged collection
of studies and essays by Archbishop Angelini
on different subjects relating to the broad
and complex world of medicine,
in terms of both scientific research
and professional practice, in close connection
with moral theology and pastoral care

The book deals with key concerns at present
as regards health, the care of the sick,
and the professional activity of doctors
and all who work in this field

As the title, taken from the Bible,
suggests, the work aims at the diverse facets
of health and illness, science
and medical research, and medical ethics
in the context of the defense,
promotion, and celebration of life
and the dignity of the human person

The edition is available only in Italian

(Vatican Polyglot Press, 1990. 578 pages)

TO OUR READERS

1. THE JOURNAL *"DOLENTIUM HOMINUM"*

1991 subscriptions to *"Dolentium Hominum"* will cost 60,000 Italian Lire (U.S. $ 60 or the equivalent in local currency), including mailing.

Our readers will understand this increase if they bear in mind that the first issue of the year alone, containing the *Proceedings of the International Conference* organized by the Office, contains as many pages as three normal issues.

2. THE SIXTH INTERNATIONAL CONFERENCE AT THE VATICAN

The Sixth International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers, to be held at the Vatican City Synod Hall, November 21-22-23, 1991, is devoted to "Drugs and Alcohol."

The meeting will bring together scientists and experts from around the world in the fields of medicine, social problems, psychology, ethics, and pastoral care.

For more information contact our Office. Our address and telephone number are indicated in this journal.

JOURNAL OF THE PONTIFICAL COUNCIL FOR PASTORAL ASSISTANCE TO HEALTH CARE WORKERS

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In the next issue

The *Proceedings* of the Fifth International Conference, on "The Human Mind," will soon be published. The International Conference was organized by our Pontifical Council and took place in the Vatican City Synod Hall, November 15-16-17, 1990. Those not subscribing to our journal may purchase the *Proceedings* through our Office by sending a check for U.S. $ 60 (60,000 Lire) or by paying this amount into our Italian postal account, no. 63353007, under the name of the Pontifical Council for Pastoral Assistance to Health Care Workers - Via della Conciliazione, 3 - 00193 Rome.

We wish to advise our subscribers that, unless notified to the contrary, we shall assume that subscriptions are to be renewed for 1991.