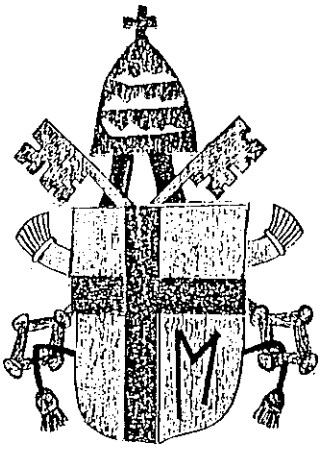

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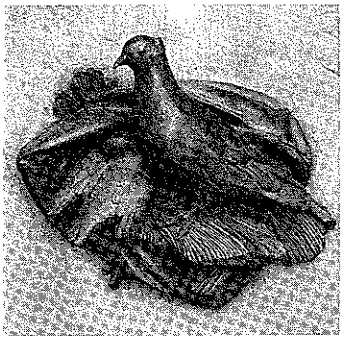
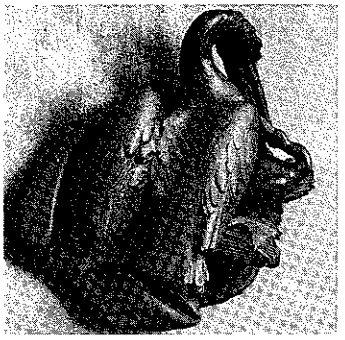
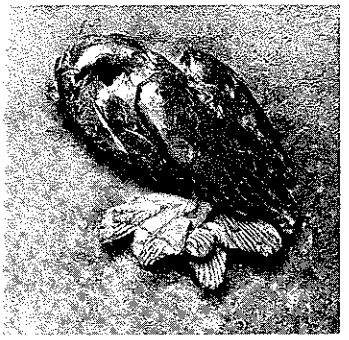


The illustrations in this issue have been taken from **Manzù, le porte** *(Milan: Silvana, 1989). The photographs are by Aurelio Amendola and represent special preliminary studies of the doors in cast bronze by the Italian sculptor: the Door of Death in St. Peter's Basilica, the Door of Love in the Salzburg Cathedral, and the Door of Peace and War in St. Laurence's Church in Rotterdam.*





Joannes Paulus episcopus Servus Servorum Dei

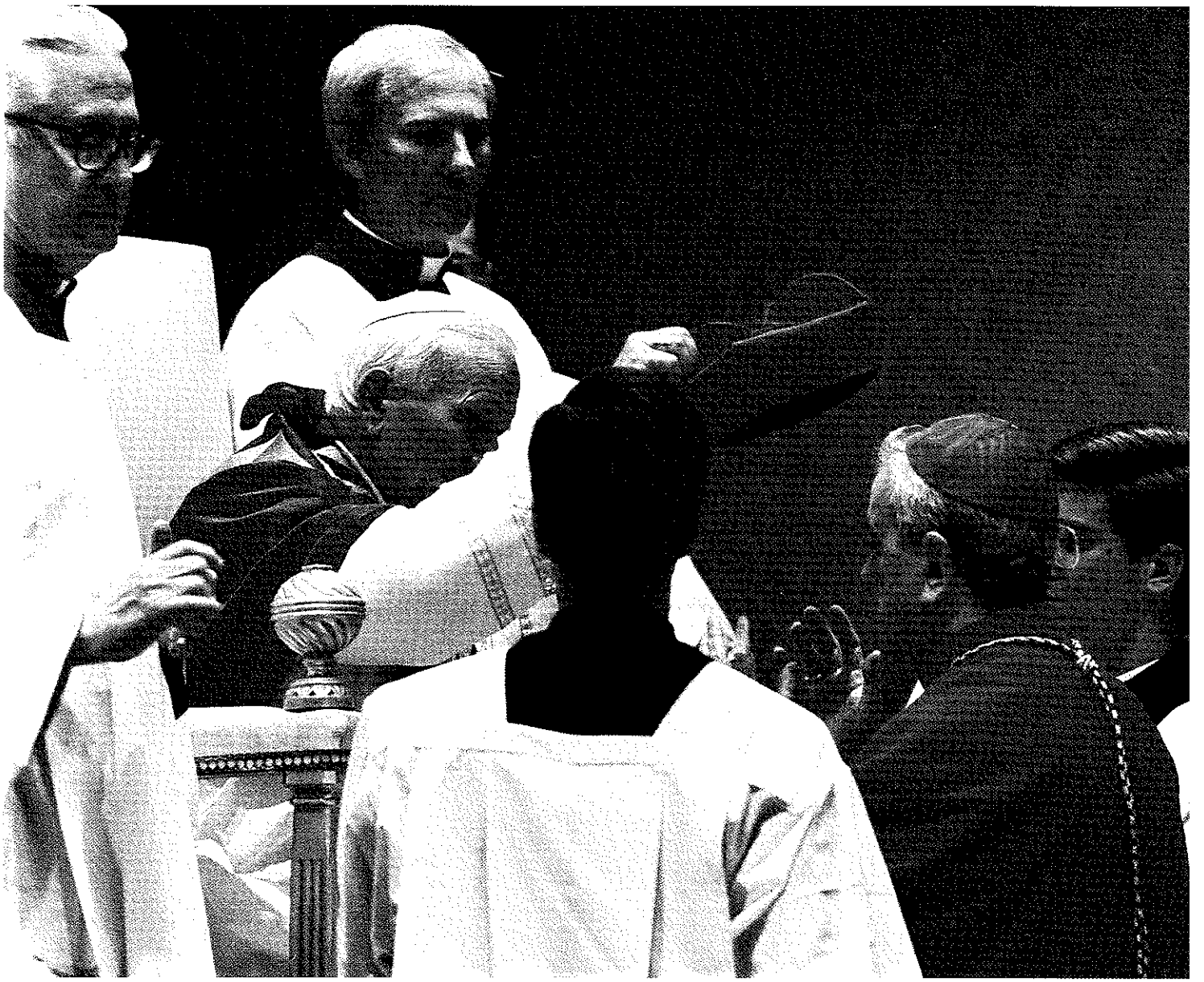
Venerabili Fratri **Florentio Angelini**, Praesidi Pontificii Consilii de Apostolatu pro valetudinis Administris, electo Sanctae Romanae Ecclesiae Cardinali, salutem et Apostolicam Benedictionem. Cum Nobis sit visum te, Venerabilis Frater, dotibus ornatum deque catholica Ecclesia bene meritum, in Purpuratorum Patrum Collegium cooptare, hoc in Consistorio, Apostolica Nostra potestate te Cardinalem Diaconum renuntiamus, cum omnibus iuribus et officiis Cardinalium tui ordinis propriis, assignantes tibi insigne huius almae Urbis templum **Sancti Spiritus in Saxia** cuius rectori atque clero ceterisque omnibus, qui eidem sunt addicti, patenter suademus, ut te, cum eius possessionem capies, laetissimo animo suscipiant ac peramanter colant. Ceterum dum summo afficimur gaudio quod, in catholicae Ecclesiae senatum allectus, ad suprema gerenda negotia Nobis sis auxilio Romanaeque Sedi honori, benignissimo Deo enixas admovemus preces ut suis te cumulet donis, gratia et ope iugiter confirmet. Datum Romae, apud S. Petrum, die duodetricesimo mensis Junii, pridie Sollemnitatem Sanctorum Apostolorum Petri et Pauli, anno Domini millesimo nongentesimo nonagesimo primo, Pontificatus Nostri tertio decimo.

Joannes Paulus PP II

Franciscus Chiarini Croton Asport

JOHN PAUL, BISHOP, SERVANT OF THE SERVANTS OF GOD

"To our venerated Brother FIORENZO ANGELINI ... in view of the distinguished qualities which adorn you and the merits acquired in relation to the Catholic Church, during this Consistory, by virtue of our apostolic authority, We proclaim you to be a Cardinal Deacon *with all the rights and duties which are proper to Cardinals of your Order. In this noble City we assign to you the illustrious church of the Holy Spirit in Sassia ...."*



The Holy Father imposes the biretta
on Fiorenzo Cardinal Angelini
(June 28, 1991)

The Service Rendered to the Sick Is a Living Sign of Charity

THE WORDS ADDRESSED BY THE HOLY FATHER TO FIORENZO CARDINAL ANGELINI

On Friday, July 5, 1991, the Holy Father received Fiorenzo Cardinal Angelini, President of the Pontifical Council for Pastoral Assistance to Health Care Workers. Relatives and friends of the newly created Cardinal attended the encounter, which took place in the Throne Room. The Holy Father's words follow below.

I am happy to receive Your Eminence, together with your relatives, collaborators at the Pontifical Council for Pastoral Assistance to Health Care Workers—especially the Secretary, Fr. José Luis Redrado Marchite, and the Undersecretary, Fr. Felice Ruffini—and all your numerous friends, witnesses to the long and intense service Your Eminence has rendered to the Church.

Immediately after your elevation to the cardinal's purple, I am glad to recall the itinerary of your ministry with gratitude. From the period when, in the hard times of the last war, you as a young priest began to devote yourself to the simple, poor people of Rome's housing projects, bringing into existence a systematic charitable service for the poorest among the Romans, to the moment when in Catholic Action you organized effective demonstrations on a national level. My predecessor, Pius XII, as is well known to everyone, appreciated your work and gave you conspicuous signs of his approval.

The work which has, however, engaged your life more than any other has been that of pastoral care in the field of health. Especially in this Diocese of Rome, in exemplary fashion you succeeded in organizing chaplains' spiritual service at hospitals and nursing homes, while your motto has been to make the countenance of suffering more human. You have done your utmost so that patients' conditions may be better explored and understood, for the purpose of bringing them relief in a Christian manner, with charity and justice. In organizing helpful meetings to study the relations between medicine and morality, moreover, you have not been afraid to provide opportune incitement so that the world of medical science will also deal with the problems—sometimes difficult, but of the greatest current interest—of the new forms of suffering.

The Church is grateful to you for this, as she is also thankful for the attention recently devoted to the world of Eastern Europe and the most urgent problems emerging therein today in the field of health.

I express my sincere hope that your service will continue to yield good fruit so as to be a living sign of charity, inspired by the model of the Heart of Christ.

In inviting all your collaborators to do their best at your side so that the work of the whole Council for Pastoral Assistance to Health Care Workers may effectively foster the tasks of formation, study, and action in the health sector, I impart to you and all present the Apostolic Blessing.

The Old and the New

REFLECTIONS ON THE ENCYCLICALS
REDEMPTORIS MISSIO *AND* CENTESIMUS ANNUS

Fiorenzo Cardinal Angelini

I. Health Care, Policy, and Ministry in Redemptoris Missio

In a little over seventy years there have been seven Pontifical documents and an Ecumenical Council Decree on the specific topic of the missionary mandate or the so-called *missio ad gentes*.[1]

If to these we add the annual Pontifical Messages for World Missions Day and the countless directives of the Congregation for the Evangelization of Peoples, we obtain a measure of the Pastor of the Universal Church's concern for this essential and central aspect of evangelization

John Paul II recalls three motives to stress the primary significance of missionary evangelization: "In the first place," the Pope states, "because in the history of the Church the missionary impulse has always been a sign of vitality, just as its decrease is a sign of a crisis in faith";[2] secondly, because it "constitutes the first service which the Church can render to each man and all humanity in the contemporary world";[3] finally, because "the number of those who do not know Christ and do not form part of the Church is continually increasing—indeed, since the end of the Council it has practically doubled."[4]

That being stated, two observations causing an immediate impression on reading John Paul II's recent Encyclical *Redemptoris Missio* strike me as a motive for serious reflection: the Pope states that the mission Christ the Redeemer has entrusted to the Church "is still at its beginnings" and "far from being fulfilled."[5] Now then, on finishing a reading of the Encyclical, it is impossible not to notice that no other missionary document of the ecclesiastical Magisterium in memory devotes so much space to the problems of health care, policy, and ministry. Let no one think the meaning is being forced as a reflection of the not unusual habit of making Pontifical documents say everything and the opposite of everything, according to the standpoint from which they are read and interpreted. John Paul II, to whom we owe the broadest and deepest document on the Christian meaning of human suffering (the Apostolic Letter *Salvifici Doloris*, February 11, 1985), has clearly stated that if man is "the way of the Church," he is such "in a special manner when suffering enters his life";[6] he has also affirmed that concern for the sick is and must be considered by the Church an "integral part of her mission,"[7] and precisely in carrying out this mission the Church recognizes "a fundamental moment" in her work in history, above all in our time[8]

I thus believe it is right and proper—as a result, too, of the priority attention the Pontifical Council for Pastoral Assistance to Health Care Workers devotes to the health ministry in the missions[9]—to indicate the essential orientations offered us in this field by *Redemptoris Missio*.

These orientations concern the subjects of *health*, understood to be physical, psychic, and spiritual well-being; *health policy*, referring to structures for promotion, prevention, and care; the *health ministry* as evangelization conducted by giving priority to approaching those suffering in body and in spirit, both individually and collectively.

This threefold dimension is welded together by a statement we read in the Encyclical's central portion: *The Gospel witness to which the world is most sensitive is that of attention to people and charity towards the poor and children, towards the suffering. The gratuitousness of this attitude and these actions, which sharply contrast with the selfishness present in man, causes specific questions to arise which orient one towards God and the Gospel.*[10] There is a return—though under a missionary aspect and for a missionary purpose—of the unitary vision of the world and mankind from which John Paul II's Magisterium draws inspiration in its insistence on the concept of a new, universal solidarity rendered indispensable by the growing interdependence among peoples,[11] in the direction of which major scientific and technological progress should move if it wishes to be an instrument of a culture of life and not a culture of death.[12]

The Pope constantly bears in mind the whole man and all men. Moreover, the Church's missionary action, as both evangelization and re-evangelization, seeks to take up the challenge of modern society on a worldwide scale[13]

Health Policy and Care

The human and Christian concept of *health* refers directly to that of salvation. "Liberation and salvation," brought by the Kingdom of God, reach the human person in both his physical and spiritual dimensions. Two gestures characterize Jesus' mission: healing and forgiving. The multiple cures demonstrate his great compassion in the face of human indigence; but they also signify that in the Kingdom there will no longer be either illnesses or sufferings and that his mission aims from the outset to liberate people from them." [14] Physical, psychic, and spiritual health involve the one mission of Christ. And as, historically, Christ acted by working healings of illnesses of the body and of the spirit, so the Church, in her missionary work, has always associated attention to the suffering with catechesis. Very often, according to local circumstances, in territories being initially evangelized, alongside the church or place of worship an outpatient clinic or hospital has arisen; indeed, in some cases it has preceded the former in time. Why? Because in the past, as today, this is the Gospel witness to which the world "is most sensitive"; and it is so because safeguarding and recovering health are the first, most universal, and most pressing demands emerging from man.

If this is the demand, only a response inspired by love can take it up entirely.

Indeed, as regards the multiple Christian institutions at the service of those suffering (clinics, leprosariums, care facilities for the handicapped and the elderly, etc.), the Pope states that "it is... these works which bear witness to the soul of all missionary activity: love, which is and remains the motive of the mission." [15]

Through service to the suffering Christ reveals to the world who God is: a Father sensitive to the needs and sufferings of every man—a loving Father full of compassion, who forgives and freely grants the graces requested." [16]

The announcement of the Kingdom of God initiates in its hearers an itinerary of conversion to God's project, "to which the Church contributes with her witness and her activities, such as dialogue, human advancement, commitment to justice and peace, education and care of the sick, assistance to the poor and children, always firmly maintaining the priority of transcendent, spiritual realities, the premises for eschatological salvation." [17] Accordingly, "the Church and missionaries are promoters of development, too, with their schools, hospitals, and so forth." [18] which, however, as structures remain mere instruments, for they are destined for man—i.e., "the protagonist of development." And here the Holy Father recalls a concept which is dear to him and which the Pontifical Council for Pastoral Assistance to Health Care Workers regards as one of its pre-eminent commitments—that of humanizing both medicine and health care in all their manifestations. In fact, the Encyclical states that, "not only in cultures impregnated with religiosity, but in secularized societies as well, the spiritual dimension of life is sought out as an antidote for dehumanization." [19]

Indeed, what renders our time "at once dramatic and fascinating" [20] is the contradiction between extraordinary progress in service to man and the growing tendency towards materialistic consumerism, the loss of meaning, and the very dehumanization of these discoveries, which, instead of *healing,* impoverish man.

Health policy and care, then, are not a marginal, supplementary aspect of the "mission," but an essential component of it. And how can we avoid thinking that not the least cause of the fact that, after 2000 years, the mission entrusted by Christ to the Church is still at its beginning stage is an insufficient awareness of the primary significance of this truth? As I recalled at the recent Synod of Bishops on priestly formation in the present circumstances, is it perhaps not painful to observe that, especially in some geographical areas, the prime consequence of the crisis in priestly and religious vocations has often been priests' and religious' abandoning the places of suffering and care? And does this fact not perhaps contradict the Church's current presence and pioneering action in caring for drug addicts, AIDS victims, the marginalized, and refugees from the Third World?

Suffering is the first human reality which interpellates the Church—suffering of the body and of the spirit—just as it was the first human reality to interpellate Christ, who, in coming to grips with it, revealed Himself to be "the physician of souls and bodies."

Pastoral Care in the Health Field

In *Redemptoris Missio* John Paul II, in citing his first Encyclical, *Redemptor Hominis,* recalls that "the Redemption which has taken place by means of the Cross definitively restored to man dignity and the meaning of his existence in the world." [21]

In this "mission" of Jesus is the best definition of pastoral care in the health field, which is service to those suffering in terms of making the best use of that suffering. "Christ at the same time taught man to do good with suffering and to do good to those suffering. Under this twofold aspect he thoroughly revealed the meaning of suffering." [22]

The terrain of pastoral care in health, within missionary evangelization, is so evi-

dent as to appear obvious In recalling the Council text *Gaudium et Spes,* the Encyclical *Redemptoris Missio* states, "The Church knows that man, 'incessantly urged on by the Spirit of God, can never be entirely indifferent to the problem of religion', and 'will always have a wish to know—at least in a confused way—what the meaning of his life, activity, and death is'." [23] And no situation awakens these fundamental questions to the point of exasperation by postulating an unpostponable response as does that of suffering

In this regard, the Holy Father addresses a pressing invitation: "The sacrifice of the missionary must be shared and sustained by that of the faithful. For this reason, I recommend that those carrying out their pastoral ministry among the sick be instructed as to the value of suffering and encouraged to offer it to God for the missionaries By such an offer the sick also become missionaries, as some movements arising among them and for them stress." [24]

It strikes me as interesting to point out that the concept of *missio ad gentes* here extends to that more general concept of mission by which—as the Council has stated—the whole Church is "by its nature missionary." [25] And it was John Paul II, at the outset of his pontificate, who expressly asked the sick for the offering of their prayers and suffering for his magisterium and ministry [26]

The frequent visits to Catholic health facilities in missionary countries confirm that the Church's care to provide for medical attention—both preventive and therapeutic—is characterized by constant commitment so that the safeguarding and recovery of physical health will always be accompanied by awareness of the constructive value of suffering.

The Encyclical *Redemptoris Missio* is not a document meant to illuminate a sector of the Church's life and activity. It is an ecclesiological text of great value, particularly today, when, alongside the problem of initial evangelization, that of re-evangelizing vast areas with a Christian tradition poses itself. And that is not all, but the missionary dimension, in a society experiencing a growing shift of masses, remains *ad gentes,* not only in "far-off countries," but all around us.

Finally, I would like to stress that it is not a recent gift and grace that the relatively young activity of the Pontifical Council for Pastoral Assistance to Health Care Workers can avail itself of a constant doctrinal reference in the teaching of John Paul II, whose magisterium is marked throughout by appeals to the foundations of pastoral care in health, with illuminating directives which we are duty-bound to be familiar with, meditate upon, and delve into, for no pastoral activity can be regarded as effective where a secure doctrinal basis is lacking, all the more necessary in a time characterized by increasingly numerous and complex problems in medical ethics The teaching of John Paul II may be summed up as a "theology of life" which constitutes the clearest and richest support for all pastoral care in health, which is service to that very life which Christ came to the earth to give us abundantly.

II. The Social Dimension of the Church in the Encyclical Centesimus Annus

A great deal has already been written on the social Encyclical *Centesimus Annus,* published to commemorate the hundredth anniversary of Leon XIII's *Rerum Novarum* Once more we are struck above all by the clarity and firmness with which the Holy Father, drawing inspiration expressly from the Gospel image of the scribe who has become a disciple of the Kingdom of Heaven, in this Encyclical has sought to take from the Church's doctrinal treasure "new things and old." [1]

The large-audience press has been particularly concerned about identifying and indicating the "new things" contained in *Centesimus Annus.* In reality, the whole document is imbued with a concern and effort to look to the Church's social teaching in its *perennial character,* or, if we prefer, in its *perennial novelty.* Indeed, at the beginning of the Encyclical, it is stated that the rereading of *Rerum Novarum* carried out by *Centesimus Annus* seeks to "look backwards," but also "look around," and "look to the future." "In doing so," the Pope writes, "not only will the permanent value of this teaching be confirmed, but there will be a manifestation of the real meaning of the tradition of the Church, which, ever living and vital, builds on the foundation laid by our fathers in the faith and, chiefly, on that which the Apostles transmitted to the Church in the name of Jesus Christ, the foundation whom no one can replace." [2]

At the close of the Encyclical John Paul II writes that "the *real novelty of things,* in every time, comes from the infinite divine power, who says, 'Behold, I make all things new' "; and he adds, "The Christian well knows that the *newness,* which we await in its fullness at the return of the Lord, has been present since the creation of the world and, more properly, since God became man in Jesus Christ and with Him and through Him made a new creation " [3]

The Perennial Newness

What is, then, this perennial novelty of the Church's social doctrine?

The perennial novelty, at once the new and the old in the Church's teaching, is this: "In the third millennium as well," the Pope says, "the Church will be faithful in *making man's way her own,* aware that she is not proceeding alone, but with Christ her Lord It is He who has made the way of man his own and guides him even when man does not realize it." [4]

To comprehend the meaning of the phrase "to make man's way her own" in depth, I feel we should take into account three key points in the Pope's new Encyclical.

In the first place, it speaks of the Church's action—performed both individually and on a community level—as a "vast movement for the defense of the human person" spanning all history;[5] it is then asserted that "there is no real solution to the social question outside the Gospel and, furthermore, *new things* can find therein room for their truth and proper moral formulation";[6] finally, it is specified that "for the Church the social message of the Gospel must not be regarded as a theory, but first of all as a foundation and motivation for action." Indeed, the Pope is so careful not to regard the Gospel as a social theory that he stresses that "the Church does not have models to propose" since "real and truly effective models can arise only in the framework of different historical situations, thanks to the effort of all those responsible for dealing with concrete problems under all their social, economic, political, and cultural aspects, which are interwoven." [7]

The perennial character of the Church's "social" reference is constituted by a priority and primary attention to man, to the dignity of his person, to the foundation of his basic rights. Repeatedly, in *Centesimus Annus,* John Paul II cites the Council text *Gaudium et Spes,*[8] which states that "man... is the only creature on earth that God has wanted for his own sake." [9] Social doctrine must, then, flow precisely from Christian anthropology, which sees man at the summit and center of all creatures and considers him in the elevation acquired through the human incarnation of God Not man as an archetype, not abstract man, but historical man in his unrepeatable personal individuality. The Church has turned her attention to this man in the course of her history and seeks to do so today.

Attention to Suffering

The story of the Church is the story of the way she has sought to make man's way her own. "Spurred by this message, some of the first Christians distributed their possessions to the poor, bearing witness to the fact that, in spite of the differing social origins, pacific and solidary life together was possible. With the strength of the Gospel, in the course of the centuries, the monks cultivated the lands, men and women religious founded hospitals and asylums for the poor, and confraternities, along with men and women of all condi-

tions, committed themselves to the needy and marginalized, convinced that the words of Christ—'Every time you do these things to one of my least brothers you do them to me' (*Mt* 25:40)—ought not to remain a pious wish, but become a concrete life commitment." [10]

Paradoxically, the social relevance of *Centesimus Annus* lies precisely in offering a global vision of the problems of social justice which have always afflicted mankind and for which it takes a long time to find solutions. Without wishing to offer a complete social theory, the Pope formulates a much more organic social doctrine in its basic articulations

than those attempted in the modern and contemporary age by multiple schools of thought.

An analysis of the encyclicals and other social documents published by John Paul II brings out in the manner of a crescendo the association of assistance to those suffering in body and in spirit with the concept of justice. In the Apostolic Exhortation *Christifideles Laici,* the Pope had spoken of this mission of the Church as one of its "basic moments" in our time.[11] In *Centesimus Annus* he attempts a reading of the history of the Church in the light of this truth.

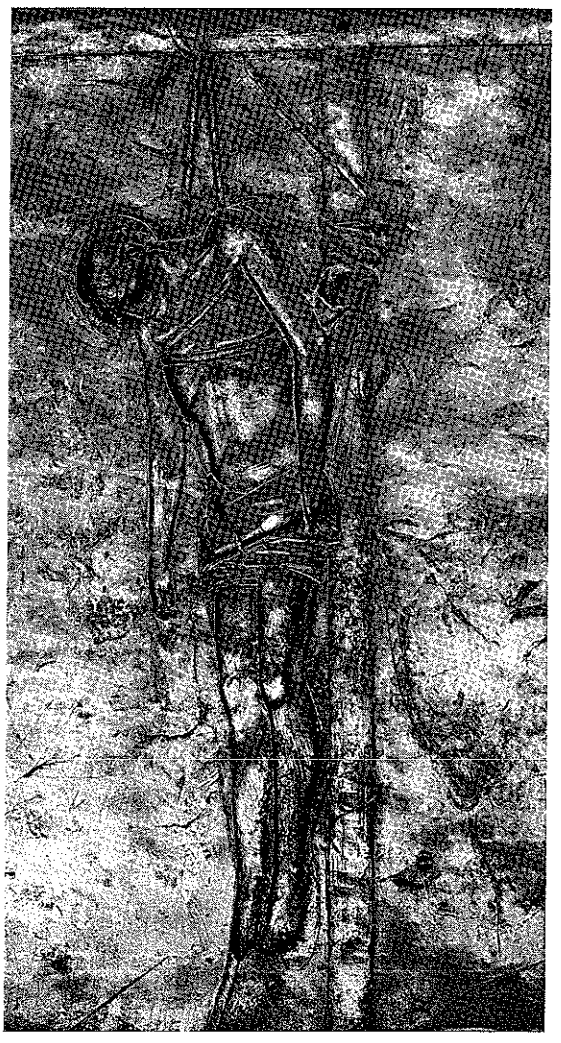
The enlightened humility of the Pontifical teaching moves along the track of a bimillenary historical experience. In reality, the Church is the oldest institution in existence and the one presenting the greatest note of continuity; therefore, like the wise scribe of the Gospel, she brings forth from her coffer the old and the new, convinced, as St. Augustine says, that the new is concealed in the old and the old is revealed in the new. In fact, it is historical, concrete man, considered and aided in his individuality, who is at once old and new, immutable and changeable. The dynamism implicit in the Church's social doctrine mirrors man's vitality and dynamism and his condition on earth.

A hundred years after *Rerum Novarum* history has shown Leon XIII to be right in his assertions on the risks of materialistic collectivism, then on the rise; the future will undoubtedly corroborate the statements in *Centesimus Annus* on the risks of savage capitalism. However, unlike the major basic texts for the opposing social systems of our time, in the teaching of *Centesimus Annus* there is no trace of intellectual arrogance or a spirit of diffident sufficiency.

In referring to the solution to the workers' question, Leon XIII, in *Rerum Novarum,* wrote, "The solution to such an arduous problem requires the contribution and effective cooperation of others." [12] "This observation," writes the Pope in *Centesimus Annus,* "has become a permanent element in the Church's social doctrine." [13]

The social question is reaching immense proportions in the world. Within it, the health dimension is preeminent and, in two-thirds of the world, an absolute priority. The hope that a constructive solution to it will be found can start only from the increased awareness of the need for men to move towards a new solidarity, for only "together" will people come to know the ways of justice and peace, which are the only "way" for man. But on this way attention to suffering is a challenge to and measure of the Church's fidelity to her social doctrine. Precisely because the Church's social doctrine is not a "system," an "economic theory," but rather a leaven which must ferment social

reality, the credibility of this doctrine largely depends on Christians' consistency in implementing it. And the immediate acid test—at once the most universal and urgent, the one which is not subject to debate and where all can find a place to meet—is the world of health policy and care. It has been throughout the history of the Church, which in this field has written her most glorious—and also her most secret and humble—pages. It is such to a larger extent today, in a society where the poor suffer from illnesses which science is able to wipe out and all are afflicted with a pathology of the spirit which only the "good news" of the Gospel can heal.



I. Redemptoris Missio

[1] Benedict XV, Apostolic Letter *Maximum Illud* (Nov. 30, 1919); Pius XI, Encyclical *Rerum Ecclesiae* (Feb. 28, 1926); Pius XII, Encyclical *Evangelii Praecones* (June 2, 1951), Encyclical *Fidei Donum* (April 21, 1957); John XXIII, Encyclical *Princeps Pastorum* (Nov. 28, 1959); Second Vatican Council, Decree *Ad Gentes* (1965); Paul VI, Encyclical *Evangelii Nuntiandi* (Dec. 8, 1975); John Paul II, Encyclical *Redemptoris Missio* (Dec. 7, 1990).

[2] Redemptoris Missio, 2.

[3] *Ibid.*, 2.

[4] *Ibid.*, 3.

[5] *Ibid.*, 1.

[6] *Salvifici Doloris*, 3.

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

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

[9] Cf. Proceedings of the First Plenary Assembly (February 1990) of the Pontifical Council for Pastoral Assistance to Health Care Workers.

[10] *Redemptoris Missio*, 42.

[11] Cf. Encyclical *Sollicitudo Rei Socialis*, 42.

[12] *Ibid.*, 42-44.

[13] *Redemptoris Missio*, 3-4.

[14] *Ibid.*, 14.

[15] *Ibid.*, 60.

[16] *Ibid.*, 13.

[17] *Ibid.*, 20.

[18] *Ibid.*, 58.

[19] *Ibid.*, 58.

[20] *Ibid.*, 38.

[21] *Ibid.*, 2.

[22] Apostolic Letter *Salvifici Doloris*, 30.

[23] *Redemptoris Missio*, 28.

[24] *Ibid.*, 78.

[25] Council Decree *Ad Gentes*, 2.

[26] Cf. F. Angelini, "La teologia della sofferenza nel pensiero di Giovanni Paolo II," in *Quel soffio sulla creta* (Rome, 1990), pp. 154-161.

II. Centesimus Annus

[1] *Centesimus Annus*, 3.

[2] *Ibid.*, 3.

[3] *Ibid.*, 62.

[4] *Ibid.*, 62.

[5] *Ibid.*, 3.

[6] *Ibid.*, 5.

[7] *Ibid.*, 43.

[8] *Gaudium et Spes*, 24.

[9] Cf. *Centesimus Annus*, 11 and 53.

[10] *Ibid.*, 57.

[11] *Christifideles*, 38.

[12] *Rerum Novarum*, 107.

[13] *Centesimus Annus*, 60.

The Problem of Threats to Human Life

Joseph Cardinal Ratzinger

I. The Biblical Foundations

To deal adequately with the problem of threats to life and to find the most effective way to defend human life against these threats, we must first of all determine the essential components, positive and negative, of the contemporary anthropological discussion.

The essential point of departure is, and remains, the biblical vision of man, formulated in an exemplary way in the accounts of creation. The Bible defines the human being in his essence (which precedes all history and is never lost in history) with two distinctive features:

1. Man is created in the image and likeness of God (*Gn* 1:26); the second account of creation expresses the same idea, saying that man, taken from the dust of the earth, carries in himself the divine breath of life. Man is characterized by an immediacy with God that is proper to his being; man is *capax Dei* and because he lives under the personal protection of God, he is "sacred": "If anyone sheds the blood of man, by man shall his blood be shed; for in the image of God has man been made" (*Gn* 9:6). This is an apodictic statement of divine right which does not permit exceptions: human life is untouchable because it is divine property.

2. All human beings are one because they come from a single father, Adam, and a single mother, Eve, "the mother of all the living" (*Gn* 3:20). This oneness of the human race, which implies equality and the same basic rights for all, must be solemnly repeated and inculcated again after the flood. To affirm again the common origin of all men, the tenth chapter of Genesis fully describes the origin of all humanity from Noah: "These three were the sons of Noah, and from them the whole earth was peopled" (*Gn* 9:19).

Both aspects, the divine dignity of the human race and the oneness of its origin and destiny, are definitively sealed in the figure of the second Adam, Christ: the Son of God died for all, to unite everyone in the definitive salvation of divine filiation. And so the common dignity of all men appears with total clarity: "There is neither Jew nor Greek, there is neither slave nor free person, there is not male and female; for you are all one in Christ Jesus" (*Gal* 3:28).

This biblical message, identical from the first page to the last, is the bedrock of human dignity and human rights; it is the great inheritance of the authentic humanism entrusted to the Church, whose duty is to incarnate this message in every culture, and in every constitutional and social system.

II. The Dialectics of the Modern Age

If we look briefly at the modern age, we face a dialectic which continues even today. On the one hand, the modern age boasts of having discovered the idea of human rights inherent in every human being and antecedent to any positive law, and of having proclaimed these rights in solemn declarations. On the other hand, these rights, thus acknowledged in theory, have never been so profoundly and radically denied on the practical level. The roots of this contradiction are to be sought at the height of the modern age: in the Enlightenment theories of human knowledge and the vision of human freedom connected with them, and in the theories of the social contract and their idea of society.

The fundamental dogma of the Enlightenment is that man must overcome the prejudices inherited from tradition; he must have the boldness to free himself from every authority in order to think on his own, using nothing but his own reason. From this point on, the search for truth is no longer conceived of as a community effort, in which human beings joined in space and time help each other to discover better what is difficult to discover on one's own. Reason, free from any bond, from any relation with what is other, is turned back on itself. It winds up being thought of as a closed, independent tribunal. Truth is no longer an objective datum, apparent to each and every one, even through others. It gradually becomes something merely external, which each one grasps from his own point of view, without ever knowing to what extent his viewpoint corresponds to the object in itself or what others perceive.

The very truth about the good becomes unattainable. The idea of the good in itself is put outside of man's grasp. The only reference point for each person is what he can conceive on his own as good. Consequently, freedom is no longer seen positively as a striving for the good which reason uncovers with help from the community and tradition, but is rather defined as an emancipation from all conditions which prevent each one

from following his own reason. It is termed "freedom of indifference."

As long as at least an implicit reference to Christian values is made to orient the individual reason toward the common good, freedom will impose limits on itself in service of a social order and of a liberty guaranteed to all.

Thus, the great theories about liberty and democratic institutions (for example, Montesquieu's) always suppose the recognition of a law previously guaranteed by God, and of universal values which these institutions, by limiting individual liberties, conspire to have respected by those who permit them to be practiced in this way. In this dynamic, the great declarations on human rights were pronounced.

The theories of the social contract were founded on the idea of a law prior to individual wills which was to be respected by them. From the moment when religions showed themselves unable to guarantee peace, being rather a cause of war, theories of the "social contract" were elaborated at the end of the 17th century (cf. Hobbes): that which would bring harmony among men was a law recognized by reason and commanding respect by an enlightened prince who incarnated the general will.

Here, too, when the common reference to values and ultimately to God is lost, society will then appear merely as an ensemble of individuals placed side by side, and the contract which ties them together will necessarily be perceived as an accord among those who have the power to impose their will on others.

To illustrate one aspect of this dialectic between theoretical affirmation of human rights and their practical denial, I would like to refer to the Weimar constitution of the first German republic of 11 August 1919. This constitution does indeed speak of basic rights, but puts them in a context of relativism and of indifferentism regarding values, which the legislators considered to be a necessary consequence of tolerance and, therefore, obligatory. But precisely this absolutizing of tolerance to the point of total relativism also relativized basic rights in such a way that the Nazi regime saw no reason to have to remove these articles, the foundation of which was too weak and ambiguous to offer an indisputable protection against their destruction of human rights.

Thus, by a dialectic within modernity, one passes from the affirmation of the rights of freedom, detached from any objective reference to a common truth, to the destruction of the very foundations of this freedom. The "enlightened despot" of the social contract theorists became the tyrannical state, in fact totalitarian, which disposes of the life of its weakest members, from an unborn baby to an elderly person, in the name of a public usefulness which is really only the interest of a few.

This is precisely the striking characteristic of the great drift currently regarding respect for life: it is no longer a question of a purely individual morality, but one of social morality, ever since states and even international organizations became guarantors of abortion and euthanasia, pass laws which authorize them, and provide the wherewithal for those who put them into practice.

III. The War on Life Today

If, in fact, today we can observe a mobilizing of forces for the defense of human life in the various "pro-life" movements, a mobilization which is encouraging and gives cause for hope, we must nevertheless frankly realize that till now the opposite movement has been stronger: the spread of legislation and practices which voluntarily destroy human life, above all the life of the weakest: unborn babies. Today we are the witnesses of a true war of the mighty against the weak, a war which looks to the elimination of the disabled, of those who are a nuisance, and even of those who are poor and "useless," in all the moments of their existence. With the complicity of states, colossal means have been used against people, at the dawn of their life, or when their life has been rendered vulnerable by accident or illness, or when it is near death.

A violent attack is made on developing life by abortion (with the result that there are 30 to 40 million a year worldwide), and to facilitate abortion millions have been invested to develop abortifacient pills (RU 486). Millions more have been budgeted for making

contraception less harmful to women, with the result being that most chemical contraceptives on sale now act primarily against implantation, i.e., as abortifacients, without women knowing it. Who will be able to calculate the number of victims from this massacre?

Surplus embryos, the inevitable product of *in vitro* fertilization, are frozen and eliminated, unless they join their little aborted brothers and sisters who are to be turned into guinea-pigs for experimentation or into raw materials for curing illnesses such as Parkinson's disease and diabetes. *In vitro* fertilization itself frequently becomes the occasion for "selective" abortions (e.g., choice of sex), when there are undesired multiple pregnancies.

Prenatal diagnosis is almost routinely used on so-called women "at risk" to eliminate systematically all fetuses which could be more or less malformed or diseased. All of those who have the good fortune of being carried to term by their mother, but have the misfortune of being born disabled, run the serious risk of being eliminated immediately after birth or of being deprived of nourishment or the most elementary care.

Later, those whom illness or accident cause to fall into an "irreversible" coma will frequently be put to death to answer the demand for organ transplants or they will even be used for medical experiments ("warm cadavers").

Finally, when the prognosis is terminal, many will be tempted to hasten its arrival by euthanasia.

IV. Reasons for the Opposition to Life — the Logic of Death

But why is there this victory of legislation and antihuman practice precisely at the time when the idea of human rights seemed to have reached the point of universal and unconditional recognition? Why do even Christians, even persons of great moral formation think that the norms regarding human life could and should be part of the compromises necessary to political life? Why do they fail to see the insuperable limits of any legislation worthy of the name — the point at which "right" becomes injustice and crime?

1. At the first stage of our reflection, I think I can point to two reasons, behind which others are probably hiding. One reason is reflected in the opinion of those who hold that there must be a separation between personal ethical convictions and the political sphere in which laws are formulated. Here, the only value to be respected would be the complete freedom of choice of each individual, depending on his own private opinions.

In a world in which every moral conviction lacks a common reference to the truth, such a conviction has the value of a mere opinion. It would be an expression of intolerance to seek to impose that conviction on others through legislation, thus limiting their freedom. Social life, which cannot be established on any common, objective referent, should be thought of as the result of a compromise of interests, with a view to guaranteeing the maximum freedom possible for each one. In reality, however, wherever the decisive criterion for recognizing rights becomes that of the majority, wherever the right to express one's own freedom can prevail over the right of a voiceless minority, there is the might that has become the criterion of right.

This result is even more obvious and is extremely serious when, in the name of freedom for those who have power and voice, the fundamental right to life is denied to those who do not have the possibility of making themselves heard. In reality, in order to exist, any political community, must recognize at least a minimum of objectively established rights, not granted by way of social conventions, but prior to any political system of law. The *Universal Declaration of Human Rights*, signed by almost all the countries of the world in 1948, after the terrible experience of the Second World War, itself expresses fully, even in its title, the awareness that human rights (the most basic of which is the right to life) belong to man *by nature*, that the state *recognizes* them but does not confer them, that they belong to all human beings inasmuch as they are human beings, and not because of secondary characteristics which others would have the right to determine arbitrarily.

One understands, then, how a state which arrogates to itself the prerogative of defining which human beings are or are not the subject of rights and which consequently grants to some the power to violate others' fundamental right to life, contradicts the democratic ideal to which it continues to appeal and undermines the very foundations on which it is built. By allowing the rights of the weakest to be violated, the state also allows the law of force to prevail over the force of law. One sees, then, that the idea of an absolute tolerance of freedom of choice for some destroys the very foundation of a just life for men together. The separation of politics from any natural content of right, which is the inalienable patrimony of everyone's moral conscience, deprives social life of its ethical substance and leaves it defenseless before the will of the strongest.

Someone may ask us, however, when does the person, the subject of basic rights which must be absolutely respected, begin to exist. If we are not dealing with a social concession, but rather a *re*-cognition, the criteria for this determination must be objective as well. Now, as *Donum Vitae* (I, 1) has con-

firmed, modern genetics shows that "from the time that the ovum is fertilized, a new life is begun which is neither that of the father nor of the mother; it is rather the life of a new human being with his own growth." Science has shown "that from the first instant, the programme is fixed as to what this living being will be; a man, this individual-man with his characteristic aspects already well determined. Right from fertilization the adventure of a human life is begun, and each of its great capacities requires time to develop, and to be in a position to act." The recent discoveries of human biology recognize that "in the zygote resulting from fertilization the biological identity of a new human individual is already constituted." Certainly no experimental datum can be in itself sufficient to bring us to the recognition of a spiritual soul; nevertheless, the conclusions of science regarding the human embryo provide a valuable indication for discerning by the use of reason a personal presence at the moment of the first appearance of a human life: how could a human individual not be a human person? Regarding this question, if the Magisterium has not expressed itself in a binding way by a philosophical affirmation, it has still taught constantly that from the first moment of its existence, as the product of human generation, the embryo must be guaranteed the unconditional respect which is morally due to a human being in his spiritual and bodily totality. "The human being is to be respected and treated as a person from the moment of conception; and therefore, from that same moment his rights as a person must be recognized, among which in the first place is the inviolable right of every innocent human being to life."

2. A second reason which explains the extent of a mentality opposed to life, I think, is the very concept of morality that today is widespread. Often, a merely formal idea of conscience is joined to an individualistic view of freedom, understood as the absolute right to self-determination on the basis of one's own convictions. This view is no longer rooted in the classical conception of the moral conscience, in which (as Vatican II said) a law resounds which man does not give himself, but which he must obey (cf. *Gaudium et Spes*, no. 16). In this conception, which belongs to the entire Christian tradition, conscience is the capacity to be open to the call of truth that is objective, universal, and the same for all who can and must seek it. It is not isolation, but communion: *cum scire* in the truth concerning the good, which accompanies human beings in the intimacy of their spiritual nature. It is in this relationship with common and objective truth that conscience finds its justification and its dignity, a dignity which must always be carefully guaranteed by a continuing formation. For the Christian this naturally entails a *sentire cum Ecclesia,* and so, an intrinsic reference to the authentic Magisterium of the Church.

On the other hand, in the new conception, clearly Kantian in origin, conscience is detached from its constitutive relationship with a content of moral truth and is reduced to a mere formal condition of morality. Its suggestion, "do good and avoid evil," would have no necessary and universal reference to the truth concerning the good, but would be linked only with the goodness of the subjective intention. Concrete actions, instead, would depend for their moral qualification on the self-understanding of the individual, which is always culturally and circumstantially determined. In this way, conscience becomes nothing but subjectivity elevated to being the ultimate criterion of action. The fundamental Christian idea that nothing can be opposed to conscience no longer has the original and inalienable meaning that truth can only be imposed by virtue of itself, i.e., in personal interiority. Instead, we have the divinization of subjectivity, the infallible oracle of which is conscience, never to be doubted by anyone or anything.

V. The Anthropological Dimensions of the Challenge

1. However, it is necessary to investigate the roots of this opposition to life more deeply. And so on a second level, reflecting a more personalist approach, we find an anthropological dimension where we should pause, however briefly.

It should be noted here that western culture increasingly affirms a new dualism, where some of its characteristic traits converge: individualism, materialism, utilitarianism, and the hedonist ideology of self-fulfillment. In fact, the body is no longer perceived naturally by the subject as the concrete form of all of his relations with God, other persons, and the world, i.e., as that datum which in the midst of a universe being built, a conversation in progress, a history rich in meaning, one can participate in positively only by accepting its rules and its language. Rather, the body appears to be a tool to be utilized for one's well-being, worked out and implemented by technical reason, which figures out how to draw the greatest profit from it.

In this way even sexuality becomes depersonalized and exploited. Sexuality appears merely as an occasion for pleasure and no longer as an act of self-giving or as the expression of a love in which another is accepted completely as he or she is, and which opens itself to the richness of life it bears, i.e., a baby who will be the fruit of that love. The two meanings of the sexual act, unitive and procreative, become separated. Union is impoverished, while fertility is reduced to the sphere of a rational calculation: "A child? Certainly. But when and how I want one."

It becomes clear that such a dualism between technology and the body viewed as an object permits man to flee from the mystery of being. In reality, birth and death, the appearance and the passing of another, the arrival and the dissolution of the ego, all direct the subject immediately to the question of his own meaning and his own existence. And perhaps to escape this anguishing question, he seeks to guarantee for himself the most complete dominion possible over these two key moments in life; he seeks to put them under his own control. It is an illusion to think that man is in complete possession of himself, that he enjoys absolute freedom, that he can be manufactured according to a plan which leaves nothing uncertain, nothing to chance, nothing in mystery.

2. A world which makes such an absolute option for efficiency, a world which so approves of a utilitarian logic, a world which for the most part thinks of freedom as an absolute right of the individual and conscience as a totally solitary, subjectivist court of appeal, necessarily tends to impoverish all human relations to the point of considering them finally as relations of power, and of not allowing the weakest human beings to have the place which is their due. From this point of view, utilitarian ideology heads in the direction of *machismo,* and *feminism* becomes the legitimate reaction against the exploitation of woman.

However, so-called *feminism* is frequently based on the same utilitarian presuppositions as *machismo* and, far from liberating woman, contributes rather to her enslavement.

When, in line with the dualism just described, woman denies her own body, considering it simply as an object to be used for acquiring happiness through self-realization, she also denies her own femininity, a properly feminine gift of self and her acceptance of another person, of which motherhood is the most typical sign and the most concrete expression.

When woman opts for free love and reaches the point of claiming the right to abortion, she helps to reinforce a notion of human relations according to which the dignity of each one depends, in the eyes of another, on how much he is able to give. In all of this, woman takes a position against her own femininity and against the values of which she is the bearer: acceptance of life, availability to the weakest, unconditional devotion to the needy. An authentic feminism, working for the advancement of woman in her integral truth and for the liberation of all women, would also work for the advancement of the whole human person and for the liberation of all human beings. This feminism would, in fact, struggle for the recognition of the human person in the dignity which is due to him or her from the sole fact of existence, of being willed and created by God, and not for his or her usefulness, power, beauty, intelligence, wealth, or health. It would strive to advance an anthropology which values the essence of the person as made for the gift of self and the acceptance of the other, of which the body, male or female, is the sign and instrument.

It is precisely by developing an anthropology which presents man in his personal and relational wholeness that we can respond to the widespread argument that the best way to fight against abortion would be to promote contraception. Each of us has already heard this rebuke leveled against the Church: "It is absurd that you want to prevent both contraception and abortion. Blocking access to the former means making the latter inevitable." A similar claim, which at first sight seems totally plausible, is, however, contradicted by experience: the fact is that generally an increase in the rate of contraception is paralleled by an increase in the rate of abortion. It must be noted, in fact, that contraception and abortion both have their roots in that depersonalized and utilitarian view of sexuality and procreation which we have just described and which in turn is based on a truncated notion of man and his freedom.

It is not a matter of assuming a stewardship that is responsible and worthy of one's own fertility as the result of a generous plan that is always open to the possible acceptance of new, unforeseen life.

It is rather a matter of ensuring complete control over procreation, which rejects even the idea of an unplanned child. Understood in these terms, contraception necessarily leads to abortion as a "backup solution." One cannot strengthen the contraceptive mentality without strengthening at the same time the ideology which supports it, and therefore, without implicitly encouraging abortion. On the contrary, if one develops the idea that man only discovers himself fully in the generous gift of himself and in the unconditional acceptance of the other, simply because the latter exists, then abortion will increasingly appear as an absurd crime.

An individualistic type of anthropology, as we have seen, leads one to consider objective truth as inaccessible, freedom as arbitrary, conscience as a tribunal closed in on itself. Such an anthropology leads woman not only to hatred toward men, but also to hatred toward herself and toward her own femininity, and above all, toward her own motherhood.

More generally, such an anthropology leads human beings to hatred toward themselves. Man despises himself; he is no longer

in accord with God, who found his human creation to be "something very good" (*Gn* 1:31). On the contrary, man today sees himself as the destroyer of the world, an unhappy product of evolution. In reality, man, who no longer has access to the infinite, to God, is a contradictory being, a failed product. Thus, we see the logic of sin: by wanting to be like God, man seeks absolute independence. To be self-sufficient, he must become independent, he must be emancipated even from love, which is always a free grace, not something that can be produced or made. However, by making himself independent of love, man is separated from the true richness of his being and becomes empty. Opposition to his own being is inevitable. "It is not good to be a human being" — the logic of death belongs to the logic of sin. The road to abortion, to euthanasia and the exploitation of the weakest lies open.

To sum up everything, then, we can say: the ultimate root of hatred for human life, of all attacks on human life, is the loss of God. Where God disappears, the absolute dignity of human life disappears as well. In light of the revelation concerning the creation of man in the image and likeness of God, the intangible sacredness of the human person has appeared. Only this divine dimension guarantees the full dignity of the human person. Therefore, a purely vitalist argument, as we often see used (e.g., in the sense intended by A. Schweitzer), can be a first step, but remains insufficient and never reaches the intended goal. In the struggle for life, talking about God is indispensable. Only in this way does the metaphysical foundation of human dignity become apparent; only in this way does the value of the weak, of the disabled, of the nonproductive, of the incurably ill become apparent; only in this way can we relearn and rediscover, too, the value of suffering: the greatest lesson on human dignity always remains the cross of Christ; our salvation has its origin not in what the Son of God did, but in his suffering, and whoever does not know how to suffer does not know how to live.

VI. Possible Responses to the Challenge of Our Time

What should be done in this situation to respond to the challenge just described?

For my part, I would like to confine myself to the possibilities associated with the function of the Magisterium. Magisterial statements on this problem have not been wanting in recent years. The Holy Father tirelessly insists on the defense of life as a fundamental duty of every Christian; many bishops speak of it with great competence and force. In the past few years the Congregation for the Doctrine of the Faith has published several important documents on the moral themes regarding respect for human life. In 1974, the Congregation issued a *Declaration on Procured Abortion*; in 1980, with the instruction *Jura et Bona*, it published a statement on the problems of euthanasia and care for the terminally ill; in 1987, the instruction *Donum Vitae* confronted, in the context of dealing with medically assisted procreation, the problem of respect for human embryos, of the so-called "surplus" products of *in vitro* fertilization, of their freezing and destruction, as well as that of selective abortion following multiple implantations.

In spite of these position statements, in spite of very numerous pontifical addresses on some of these problems or on their particular aspects, the field remains wide open for a global restatement on the doctrinal level, which would go to the deepest roots of the problem and denounce the most aberrant consequences of the "death mentality."

One could think, then, of a possible document on the defense of human life, which in my opinion should have two original characteristics in respect to the preceding documents. First of all, it should not only develop its treatment of individual morality, but should also give consideration to social and political morality. More in detail, the various threats against human life could be confronted from five points of view: the doctrinal, the cultural, the legislative, the political, and finally, the practical.

And so we arrive at the second original feature of a possible new document: although there should be room for a denunciation, this would not be the main feature. Above all, it would be a matter of giving a joyous restatement of the message about the immense value of each and every human being, however poor, weak, or suffering he or she may be. The statement would show how this value is seen in the eyes of philosophers, but above all, in the eyes of God, as Revelation teaches us.

It would be a matter of recalling with wonder the marvels of the Creator toward his creation, the marvels of the Redeemer toward those he came to meet and save. It would be a matter of showing how receptivity to the Spirit entails in itself a generous availability to other people, and thus, a receptivity toward every human life from the first moment of its existence until the time of its death.

In short, against all ideologies and politics of death, it is a matter of recalling all that is essential in the Christian Good News: beyond all suffering, Christ has cleared the way to thanksgiving for life, in both its human and divine aspects.

Health Policy in the European States

Hon. Giulio Andreotti, President of the Italian Council of Ministers, for the Inauguration of the 276th Academic Year of the Lancisian Academy

I thank Professor Lumia for having invited me to the inauguration of the 276th Academic Year of this prestigious institution, which has been at the service of science and human well-being for centuries

When possible topics to be dealt with were discussed, it struck me as logical to identify a subject of considerable current interest which definitely forms part of the Academy's aims—namely, health policy in Europe

As we shall attempt to see, it is a matter of complex policies which have still not been brought very much into harmony and are the result of traditions and modes of protecting human health which are so different that they lead us to affirm that Europe and health constitute a pair which entirely remains to be achieved

Here in Rome we have just concluded an extraordinary Summit meeting, a Council of Europe session which has undoubtedly represented an important step in the long process of constructing a united Europe; the objectives for the next two intergovernmental conferences aimed at accelerating the processes of economic and monetary union, along with the political union, have been established We have acted with determination, aware that the future and prosperity of the peoples of our continent are at stake, but also because we know we must devote constant attention to prospects for a new political balance in a world which is now on a course of continued and accelerated evolution

It would, then, seem logical that, at a moment when economic and political integration appears to be a goal so close at hand, there should have been for some time real cooperation in the field of promoting and defending health through an obvious choice of values which, though remaining compatible with the rules of a community economy, considers life and its full expression as a primary goal—or, rather, I would say "a priority goal." Indeed, in the face of the need to raise the living standards of all peoples, the safeguarding of health is undoubtedly a preliminary problem. It is evident, in any event, that we must pursue a precise, universal vision—neither class-conscious nor elitist—of health; it would be paradoxical and offensive to the dignity of the human person to exalt the increasingly advanced technologies at the service of human health if there were then delays in creating laws and facilities enabling all to avail themselves of such achievements. And it is in this perspective that the warning addressed to us some time ago by the President of the Pontifical Council for Pastoral Assistance to Health Care Workers, Archbishop Angelini, should be interpreted—when he stated that "speaking of European unity and cooperation among peoples will continue to be purely rhetoric as long as there remains an inexplicable gap, as regards recovering health, in terms of receiving care in Bonn or Rome, in London or Athens, and as long as people continue to die in developing countries of malnutrition or epidemic diseases long overcome by medical science "

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In reality, if we carefully examine the state of health collaboration among the countries of Europe, we realize that, in practical terms, we have not yet succeeded in implementing a continuous and necessary exchange of advances in medicine and treatment, including preventive and rehabilitative medicine, just as effective cooperation in dealing with the very serious problems of the care and social reinstatement of the handicapped, of the organic mobilization of social volunteers, and of adapting norms and instruments suited to improving the living conditions of the elderly is still lacking

One of the main reasons for the absence of "European health care"—in the light of detailed knowledge of community mechanisms—surely derives from the lack in treaties of a specific juridical basis for health care. The Single European Act of February 17, 1986 did not itself introduce anything but a general reference to the need to guarantee health from the standpoint of environmental and consumer protection—there is, in short, a lack of any precise, specific mention of health care as a possible objective to be reached in the framework of European unity in 1992.

After detailed analysis of the question we may assert that the Brussels panorama, until just a few months ago, offered very little basis for a common initiative, if we pass over the many directives issued on pharmaceuticals and work, where the two topics are, however, dealt with from a more economic and market-oriented standpoint, with few references to health care

If, furthermore, we examine the organization of the different European healthcare systems, we can better understand some other motives which have delayed—and continue to delay—the objective of a European medicine.

The methods of financing in fact vary, as do the management and very organization of services; there are differences in method (and even in substance), in the remuneration of doctors and staff, and, above all, in the degree to which patients must contribute to the cost of health services: in short, it is not exaggerated to affirm that if there is anything regarding which the European countries appear to differ among themselves, it is precisely in the varying orientations they follow in connection with the management of national health services.

There is, however, one element which links all of them and is certainly hardly consoling: no one, in fact, feels he has identified an entirely satisfying solution to meet the health needs and requirements of his own population in the best way and at an acceptable cost.

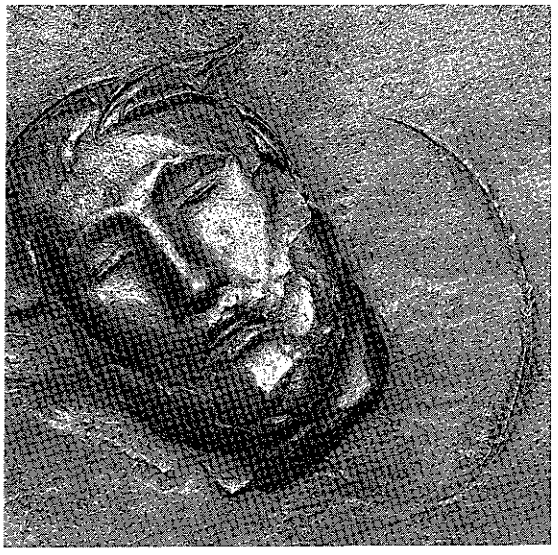
Most European countries now propose guaranteeing free care only to those less well-off, to patients with chronic diseases, and to those who must deal with costly medical services. The closest to such a position today is the German healthcare system, which, moreover, finds itself obliged to confront the not-at-all easy problem of medical assistance—and adaptation of these services to Western standards—for the new citizens of the united Germany. Other countries, like Great Britain, Ireland, Italy, Portugal, and Denmark, have formulated their conception of the healthcare system in terms of a clear predominance of the public sector over the private one; still others, such as Greece, France, and Spain, have instead opted for an underpinning equally divided between the public and the private. The countries with primarily public efforts are oriented on the assumption that institutional health systems are more competitive; those with a mixed system concentrate, on the other hand, on the possibility of the citizen's choice, fostering public/private competition.

* * *

Community institutions have up to now been inadequate, from an organizational standpoint, to the task of proper political and technical management of the problem. On a parliamentary level, for example, the questions concerning health are divided among three different Commissions, while in Brussels the situation is certainly not better, if it is true that there exists no single General Administration directly responsible for health initiatives.

We can obviously not fail to be impressed by the lack of community documents prescribing definite commitments in the health field, in contrast to the stress laid on the problems of environmental health, which will even permit the establishment of a special European agency in the near future, which we would like to see appear in Italy. It seems absurd, but even in the broader social sphere, the patrimony of common achievements is not irrelevant if we consider that next year will be the thirtieth anniversary of the European Social Charter, whereby the maturation of our civil societies was sought after a long, sometimes dramatic social history.

The Charter was to add the principle of social justice on a European level to that of



political and civil liberties; in parallel fashion, in those years the principle of national sovereignty had been corrected—and partly replaced—by that of supernational organization, increasingly fruitful.

On the other hand, only beginning in 1977 did the Health Ministers of the EEC start to study common policies for action and to imagine the first, timid processes of coordination. The most concrete result of those early consultations permitted reciprocal recognition of degrees and an agreement concerning the free exchange of services. We then had to await the preceding semester of Italy's chairmanship, in 1985, to see some important guidelines expressed and approved to solve some of the most burning current problems in health care. Common directives on the new role of the physician were set forth; norms were passed for evaluating risks to health following upon environmental pollution; all then agreed on the need to contain the cost of health services,and the idea of a European charter for patients truly

seemed close to becoming a reality. Even on that occasion, however, the good intentions and statements of principle were followed by results that were quite modest alongside expectations—concrete actions were, in short, scanty!

Just a few days ago representatives of the Europe Against Cancer Committee met in Rome. This is perhaps the most effective instrument created by the Community, and it was constituted precisely in the course of that Italian chairmanship. The program seeks to develop a twofold proposal: to avoid, by way of prevention, the manifestation of a considerable number of forms of cancer and increase, by early diagnosis, the probability of curing other forms of tumors. In this way we should succeed in reducing the number of deaths due to cancer in Europe by at least 15% by the year 2000. And I think it is rather easy to imagine a similar willingness to act together to face up to the dramatic spread of AIDS.

It is, indeed, in the vast and fundamental field of scientific research that the Community has been able to implement the most concrete initiatives, promoting collaboration among the leading scientific institutions of the Member States. With the Science and Development Coordination Program in Biomedical Research sponsored by the European Community in 1987 it has been possible to improve scientific collaboration by comparing new experiences, increasing the productivity of research, and developing the principle of a science without borders or secrets, the cornerstone for the spread of technology and universal concord. And it is only with a touch of somewhat nationalistic bitterness—which it would be foolish to want to overlook—that I must, however, observe that of the 143 coordinators of the projects connected with the EEC program only nine are Italians, as opposed to nineteen French, twenty-eight English, and twenty-nine Dutch. These are perhaps marginal aspects, but they should make our scientists reflect so that the excellent results achieved by them in often very difficult situations will not run the risk of being neglected on a Community level, possibly because of a low degree of attention and participation in decision-making moments of the program.

* * *

But the Italian Presidency regards greater recognition of the aspects related to protecting health as basic for future development, with special priority for public health initiatives, through necessary reinforcement of the instruments offered by treaties as well. Convinced of the opportuneness of this, we shall also seek to introduce this specific topic into the agenda of the next Intergovernmental Conference, on Community institutional structures, so that we can make the progress needed to introduce health care as one of the areas under Community jurisdiction.

The objective to be pursued must be effective centralized coordination which can ensure uniform conditions throughout Community territory as regards access by citizens to facilities and services, with particular attention to the categories requiring greater protection, such as children, the elderly, women expecting children, the chronically ill, and the handicapped, without overlooking, in addition, the new responsibilities of the Europe of the Twelve towards the young democracies of the East, for which the same right to health protection that Western populations are accustomed to must be ensured.

Personally, I feel that bringing the healthcare systems into line with each other is, in any case, a foregone conclusion. As has happened with the processes which have characterized—and still characterize—other sectors, it would be wise to concentrate the integration process on cautious experimentation of new solutions and a rigorous evaluation of early results rather than undertake a radical change in systems.

And in this perspective, if we examine the content of the two major models for health management, we can arrive at some interesting considerations for a future integration proposal. In both Britain and our country, for instance, the dream of going completely public has for some time been on the wane, inasmuch as it is conceived in terms of a human being with ideal behavior who does not exist in reality; as a result, some correctives have been applied, such as having the patient share in expenses and introducing the private sector into the health field.

In my view, however, the private sector has not always become part of the balance of this area in a positive way, since, while it takes advantage of the agility of private procedures as opposed to the bureaucratic-administrative public ones, it is not uniformly supported (in terms of payment rates as well) by agreements with the Regions. A sharper distinction would benefit everyone.

The recent measure by Mrs. Thatcher whereby there is an attempt to introduce into the national healthcare system the concepts of correct competition between the public and private spheres to attract the internal market, control over the quality of health services, and human resource policy is noteworthy. Beyond all doubt, the success of a healthcare system hinges upon these three points, and Italy, too, is seeking to achieve this success by, among other things, the bill being examined by the Senate. The market system is—though not automatically—the

great corrector of errors and mistaken ideas which every system generates along the way and which no law can foresee or forestall a priori: in particular, the patient should be a client on an equal footing, whether or not he pays on his own. This is also the basis for humanizing health care, which, in the Italian public system, for instance, has in some areas reached levels of degradation which are intolerable in a civilized state.

Two concepts emerge from this premise:

a) it is necessary to introduce the entrepreneurial principle into the public system;

b) the needs of the nonpaying patient must be seriously verified and overseen by the State to prevent their expansion from involving a useless and disastrous increase in costs.

This is the greatest challenge for healthcare systems today, whether they are public or private. This recalls the State to its functions, which do not concern managing health care, but programming and overseeing it, thereby ensuring, by a rational use of resources, the quality of medical attention to citizens.

And quality is measured—and implemented—first of all by way of personnel. The second challenge to modern healthcare systems is precisely to carry out an intelligent human resources policy. There is still a great deal to understand about man's behavior in the world of work, as is exemplified by the interest shown recently by Europe in Japanese personnel-management techniques since the policy of purely monetary incentives adopted for decades in the West is revealing itself to be unsatisfactory in part. Only the combination of cultural and economic motivations seems to offer prospects, and this is all the truer in the world of health. It is a matter of a broad, still unexplored field of research which should, in my view, receive greater attention for the future and prompt more intelligent, bolder choices.

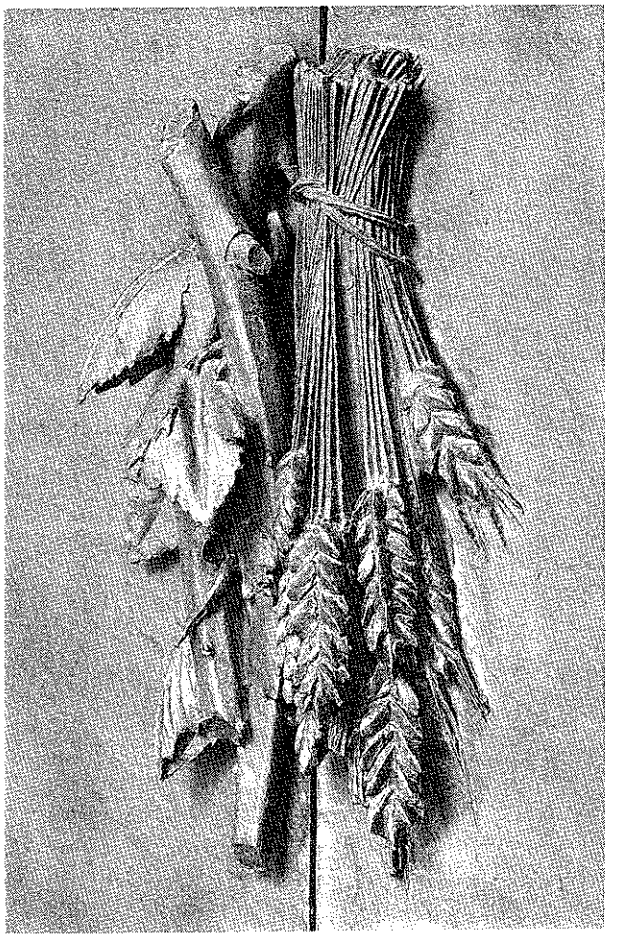
The verification of quality in medicine is not simple, but is not impossible either: it is a question of an immense field involving the general culture of a nation, and, therefore, the school and the university, first of all, as well as the culture specific to professional categories. In our country, for example, there should be a major investment in promoting both this general culture and, above all, that which is specific by means of the instruments widely tested in other countries, such as updating used as a method for programming and advancing one's career.

The common defense of the most precious good can then represent a significant acid test in order for Europe not to be perceived by citizens as something abstract, reserved for a few initiates. Europe must be felt to be a common good which interests everyone and particularly the young. By developing programs to protect human health and the environment with conviction, we shall provide Europeans with the certainty that the road remaining to be traveled is paved with concrete elements which concern and affect our daily lives, not just superficially, but deeply.

I believe I can conclude by asserting once again that the duty to ensure adequate health care for the citizens of the new Europe also represents an invitation to solidarity, not selfishness, to cooperation, not antagonism, to pooling available resources instead of fragmenting them.

It will be the task of all of us, in the near future, to gather together these demands and transform them into an occasion for progress. Then Europe, to recall Unamuno's celebrated statement *sabrá vencer y convencer*, will be able to "overcome and convince": overcome precisely the challenge proceeding from the internal evolution of its society and convince others of the universal validity of its model.

Magisterium of the Church



Excerpts from Addresses by the Holy Father

Cardinal Sodano's Address
Spanish Bishops' Message

A Moral Code Is Necessary to Regulate the Distribution of Pharmaceuticals So They Will Not Be Used Against Life

To the members of the International Federation of Catholic Pharmacists received in an audience on Saturday, November 3, 1990

Mr. President,
Ladies, Gentlemen, and Dear Friends,

1 It is with pleasure that I welcome you that have come to celebrate the fortieth anniversary of the foundation of the International Federation of Catholic Pharmacists. I thank your President, Dr Edwin Scheer, for the warm greeting he has addressed to me and for the description he has provided us with of your Federation's firm commitment to fulfill the aims valiantly traced out by its founders Four decades of growing activity confirm the importance and value of your institution.

2 You know that the Church regards solicitude towards the sick as a privileged aspect of her mission. Though particularly linked to spiritual support, this mission could not, however, overlook the health of the body. Hasn't it often left its mark on your language, in speaking of "medicinal grace" or describing virtues and spiritual values as "remedies"?

The extraordinary development of science and medical practice, of the care of the sick by society, and of preventive medicine presuppose a considerable parallel development of pharmacology In this way, the pharmacist, who has always been an intermediary between the doctor and the patient, sees the domain of his mediating function expanding. Awareness of your duties leads you to reflect increasingly on the human, cultural, ethical, and spiritual dimensions of your mission. Indeed, the relationship between the pharmacist and the one seeking remedies goes far beyond its commercial aspects, for it requires a profound perception of the personal problems of the one concerned in addition to the basic ethical aspects of the services rendered to life and the dignity of the human person

3. As I have so often had occasion to stress, pharmacists may be pressed towards nontherapeutic ends capable of violating the laws of nature, to the detriment of the person's dignity. It is, then, clear that the distribution of medicines—as well as their conception and use—must be governed by a rigorous, carefully observed moral code. Respect for this code of behavior presupposes faithfulness to some inviolable principles which the mission of the baptized and the duty of Christian witness make particularly timely today.

All of this demands from the pharmacist incessantly renewed reflection. The forms of aggression against human life and its dignity are becoming more and more numerous, particularly through the use of medicines, when they ought never to be used against life, either directly or surreptitiously. It is for this reason that the Catholic pharmacist has the duty—in accordance, moreover, with the immutable principles of the natural ethics proper to man's conscience—of being an attentive counsellor for those purchasing medicines, not to mention the moral assistance which he can give all of those who, having come to buy a product, also expect advice from him, a reason for hope, a way to be followed.

4 In the distribution of medicines, the pharmacist cannot renounce the demands of his conscience in the name of the laws of the market or obliging legislation Profit, legitimate and necessary, must always be subordinated to respect for the moral law and adherence to the Magisterium of the Church In society, Catholic pharmacists should be recognizable, at once competent and faithful witnesses, without whom the institutions and associations grouping them together for this reason would lose their reason for existence

For the Catholic pharmacist the Church's teaching on respect for life and the dignity of the human person, from his conception to his final moments, is of an ethical and moral nature It cannot be exposed to variations in opinion or applied according to fluctuating options Aware of the newness and complexity of the problems posed by the progress of science and technology, the Church makes her voice be heard more frequently and gives clear indications to health personnel, to which pharmacists belong Adhering to this teaching surely represents a difficult duty to perform concretely in your daily work, but for the Catholic pharmacist it is a question of fundamental orientations which he cannot renounce.

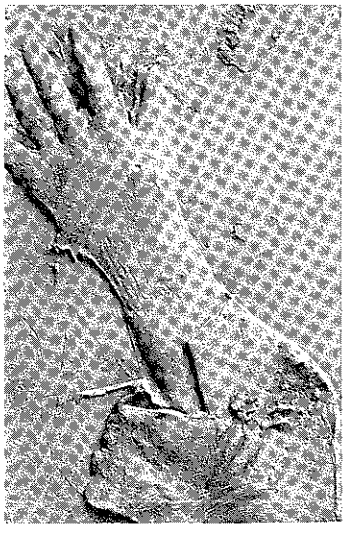
5 In the practice of your profession, you are called to be close to the users of medicine: these, for you, represent your neighbor to be considered, as with the Good Samaritan, not only in terms of his immediate needs, but as a brother who is asking for more than material aid

The Gospel speaks of a healing power which emanated from the very person of Christ; the sick and the infirm would seek

him out as the one able to heal souls and bodies. It is in this spirit that you are called to act, by virtue of your profession and your Christian faith.

This was the inspiration of your founders, whom we recall today with admiration and gratitude. Your association helps you to acquire clear awareness of your specific duties. The Church needs your witness, which can be achieved, among other things, through your action to orient the public authorities towards legislative recognition of the sacredness and inviolability of life and of all that can contribute to improving its physical, psychological, and spiritual conditions.

6 I wholeheartedly ask for the support of God's Blessing upon your Federation, you yourselves, and your families, as well as upon your daily work. May the Most Blessed Virgin, Mother of goodness and wisdom, guide you on the way of faith and in the service you render to life!



Service to the Sick and the Suffering, Who Are a Chosen Portion of the People of God

To the faithful of Santa Maria in Traspontina Parish, Rome, during the Mass celebrated on the occasion of the Pastoral Visit Sunday February 10 1991

"He healed many who were afflicted with various illnesses" (*Mk* 1:34).

Dear Brothers and Sisters, today's Gospel passage presents us with numerous throngs of sick and suffering people who press around Jesus. He comforts them with his words and, with simple but eloquent gestures, heals them and saves them.

Having come from the Father to announce and carry out the salvation of the whole man and of all men, Jesus shows particular predilection for those who are wounded in the body and in the spirit: the poor, sinners, the possessed, the sick, the marginalized. He thus reveals himself to be the "physician of bodies and of souls" (St. Ignatius of Antioch, *Ad Ephes.* 7,2), man's Good Samaritan, the only Savior of mankind.

In relation to Peter's mother-in-law, Jesus' attitude and gesture are emblematic: "Drawing near, he raised her up, taking her by the hand," the Evangelist notes. With significant consequences—"The fever left her, and she set about serving them"—to indicate, on the one hand, that the healing is an overcoming of evil and an emergence from isolation and, on the other, a restoring to "full" life which makes the person healed capable of serving others and following Christ as a disciple.

But the saving work of Christ is not exhausted with his person and in the timespan of his earthly life: it continues in the Church and through the Church, the sacrament of God's love and tenderness towards man. In sending his disciples on a mission, Jesus confers upon them a twofold mandate: that of announcing the Gospel of salvation and peace and that of "caring for the sick" (cf. *Mk* 6:3, *Mt* 10:1, *Lk* 9:1,6, 10:9).

Faithful to this teaching, the Church has written very beautiful pages and has maintained a significant presence in the world of suffering, especially through the innumerable saints of charity and the institutions and works created by them.

Assistance to the sick is an integral part of her mission. You will always have the poor and the suffering with you, Jesus warns (cf. *Mt* 26:11), and the Church continually en-

counters them on her way, regarding the sick man as the "privileged way" to encounter Christ.

This is true for our time as well, in which, in spite of the multiple achievements of science and technology, there still remain long-standing illnesses and new ones are identified. Man's condition on the earth, inner suffering, the struggle of which we have heard an echo in the confession of just and patient Job, in the first reading of this liturgy, prompts disturbing questions on the reason for life and death, on the meaning of illness and suffering, and, not infrequently, on God's fatherhood and the transcendent destiny of his children.

It is a question of real inner "lacerations" which pose existential questions to which the Church's pastoral action must respond in the light of faith, with the *Crucified One* before her eyes, where the whole saving mystery appears of God the Father, who, out of *love for all men,* did not spare his own Son (cf. *Rm* 8:32).

Life Is Threatened by Abortion, Euthanasia, Racism, and War

This is a translation of the Pope's Angelus reflection on Sunday February 3

Dear Brothers and Sisters,

1. Today is the "Day for Life" in Italy, a traditional occasion to reflect and pray, a concrete invitation to make a commitment to defend and promote human life from its beginning to its natural end. I feel the need to join my voice to that of the Italian Bishops to say, once again, courageously and clearly that "the divine law 'Thou shalt not kill' regards every person, and obliges every person regardless of his or her religious convictions, because it is the law which the Creator inscribed in consciences as a natural law" (General Audience, 30 January 1991). Politicians, therefore, administrators and those responsible for social services and health care must recognize in the love of life "the presupposition and fundamental contents of the promotion of the common good, and to try every means possible to ensure the economic, social, and cultural conditions for an effective freedom in regard to life" (From the Italian Bishops' message for Life Day).

2. "Love for life, choice of freedom." This is the day's theme and it moves us to consider the necessary connection between life and freedom. How can there be freedom where life, *every human life,* is not welcomed and loved? How can there be true social progress when people try to justify and legalize attacks and threats against human life, which is a free gift of God's providential love? When there is no respect for life, we are already in the kingdom of death: death of feelings extinguished by an unbridled, alienating hedonism; the death of a moral sense, overcome by sterile, devastating selfishness, while consciences run the risk of being closed to the truth and unable to recognize the good which alone is capable of making people happy.

Life must always be defended, welcomed with love, and accompanied with constant respect. As human beings and believers, we must never stop *promoting the culture of life* in the face of the culture of death. We must proclaim the inviolability of the right to life —and to a life with dignity—against abortion, an aberrant crime which has the qualities of totalitarianism in regard to the most defenceless human beings. We must proclaim this right against genetic manipulation which threatens the development of the person; against euthanasia and the rejection of those who are most feeble; against racism and homicidal violence of every kind. We must proclaim such a right against war—against this war which is continuing to be fought in the Persian Gulf Region with an increasing threat to all humanity.

3. May Mary, Mother of all people, accept our prayer, which echoes the anguished cry of the victims of abortion, hatred, war, and attacks on life. May she support the weak and comfort those who are suffering unjustly. May she touch the hearts of those who reject the light of truth and, by killing, bring harm to humanity itself.

With confidence we turn to you, Mother of mercy, Mother of life.

Community on a Pilgrimage

On Monday, February 11, the Feast of Our Lady of Lourdes, Pope John Paul II celebrated Mass in St Peter's Basilica for many invalids The celebration was sponsored by Opera Romana Pellegrinaggi and UNITALSI, two groups which provide for pilgrimages of the sick to the Marian shrine at Lourdes During the course of the Mass the Pope preached the homily

Dear Brothers and Sisters!

1. "Blessed are those who hear the Word of God and live it every day" (Responsorial Psalm).

Blessed are they who are open to the Truth of His Word and do not miss the opportunity offered to them to be transformed by His supernatural power. Blessed are they who, with docile confidence, follow the initiatives of the Heavenly Father and with faithful perseverance accept His mysterious will and do not stray on the path of life.

At the threshold of Lent, which is now imminent, the words which just resounded in our liturgical assembly invite believers to conversion; they invite them to trust in God in all circumstances, especially in dramatic moments like those which humanity is experiencing at the present time. They exhort us to break the barrier of doubt, of incredulity, in order to accept the divine law with generosity. God is present in the midst of His people, and He will not fail to give us the necessary help to accomplish His plan of salvation. He is God, the source of all mercy: nothing can resist the power of His love. Blessed are we if our hope is nurtured in Christ. We will never lack strength for the journey, nor will the expectation of our earthly pilgrimage be disappointed.

2. "Blessed is she who believed that the Lord's word would be fulfilled in her" (*Lk* 1:45).

This surprising availability to the plan of the Most High marked the entire existence of the Virgin most holy, which we celebrate in a special manner today. Her life, as the Council reminds us, is a continuous going forward on the pilgrimage of faith (cf. *Lumen Gentium,* 58). Each day, each moment, Mary repeats her unconditional assent to God, and through her faith, which is lived with total trust, she "shines forth on earth, until the day of the Lord shall come (cf. *II Pt* 3:10), a sign of sure hope and comfort to the pilgrim People of God" (*Lumen Gentium,* 68). Her "yes" to the Father's free initiative made her the mother of Jesus and an instrument in the hands of the Most High for the salvation of mankind.

And now, crowned as Queen of heaven and earth, she is the support and hope of mankind on its journey towards the life without end, towards eternal love, towards flawless justice and unbroken peace.

3. I am particularly pleased with today's meeting because in its suggestive, moving context of song and light it makes us experience in spirit the spiritual atmosphere of the grotto of Massabielle. At Lourdes, the presence of the Virgin most holy is almost palpable in the atmosphere of constant prayer and recollection, in the invitation to penance and conversion, in the fraternal communion which is established among the many pilgrims, especially among the sick. Like a loving mother, Mary gathers her children, the healthy and the sick, from all corners of the earth, and offers to all of them Jesus, "the fruit of her womb" (*Lk* 1:44).

I greet all of you cordially, dear Brothers and Sisters, who have wanted to take part in this meaningful celebration. I especially greet you, the beloved sick, and I want to assure each of you that I am close to you in spirit. I thank those who, with care and devotion, assist you physically and spiritually: the doctors, nurses and orderlies, the priests, religious and the many volunteers, especially among the young, who in so many ways help you and share your sufferings.

I greet the directors of UNITALSI and the *Opera Romana Pellegrinaggi,* who with their collaborators have sponsored and organized this ceremony in the Vatican Basilica, as they do every year.

This beloved annual appointment always returns so charged with spiritual emotion, not only because it makes us experience the atmosphere of Lourdes and the emotions of pilgrimage, but most of all because it is an occasion for a profound experience of the Church and of beautiful Marian devotion.

4. "As a mother comforts her child, so will I comfort you" (*Is* 66:13). These words of the prophet Isaiah also lend themselves well to the Mother of the Redeemer and take on an almost intimate tone, as if Mary were addressing them to each one of us, especially those who are tried by illness and suffering. The Virgin is consoling her children, leading them to Christ; she gives them the Savior, the only one who can give true peace and eternal salvation. Is this not perhaps the spiritual message that is typical of Lourdes?

The heart of Lourdes is the Eucharist, in which everything converges and from which everything comes. It is Jesus who passes among the sick each day, blessing them; it is the Gospel of conversion and penance which is constantly proclaimed there; it is the commandment of love which people seek to put into practice each day.

Intimately connected with the Eucharistic mystery is the priestly ministry. Priests act in Christ's name; they are called to accompany the faithful in their spiritual journey

Pilgrimage has the characteristics of a community on a journey The mission of the priests must be evident to the pilgrims and the sick who enter more easily into conversation with the priests during their common efforts on the journey: priests are men of God, ministers of the Eucharist, witnesses of charity, prophets of hope, spiritual leaders with a rich sense of humanity and dispensers of God's merciful love

Through their ministry they can help their fellow travellers recover the strength of faith which is capable of opening both healthy and sick to the horizons of God; they can encourage those whom they meet to experience personally that love is possible, sustaining them as they travel the Gospel paths with Mary in the Church.

5. Blessed is she who believed!

Blessed is the one who lives the Word of the Lord!

Dear Brothers and Sisters, may our hearts be open to the mystery of God's love,

May our lives be converted to the richness of His pardon

Thus we shall have joy, we shall have light, we shall have life,

Because God's mercy is from age to age on those who fear Him.

Forever.

Mary, Immaculate Mother of God and all people,

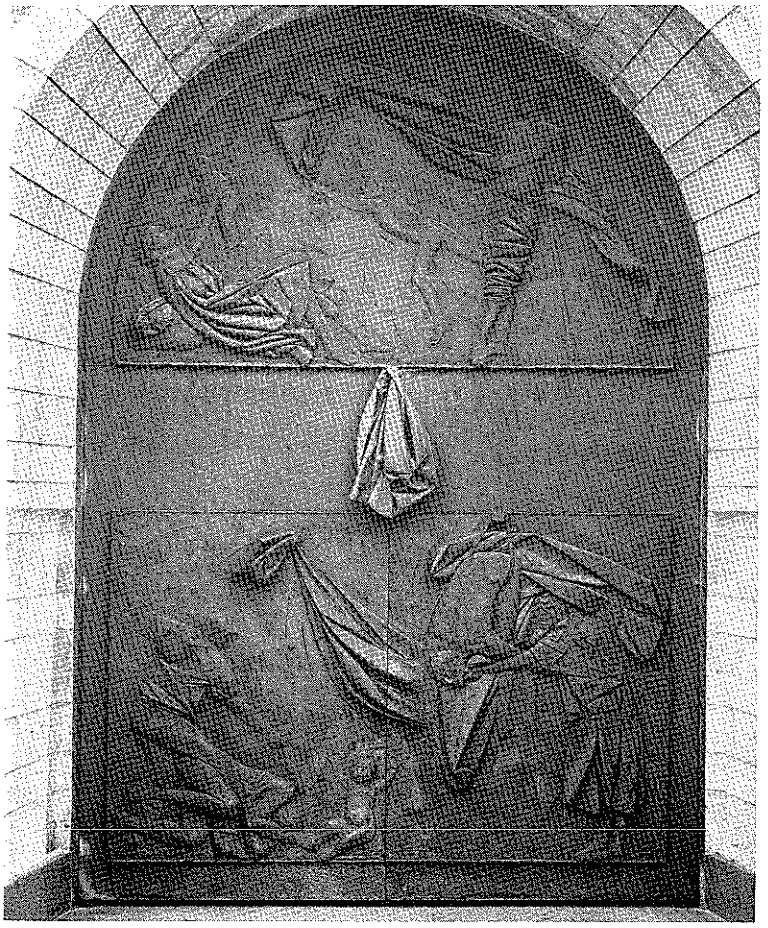
Hear the prayer of the sick,

Hear our prayer,

Grant peace to the world;

Give us Jesus, our true peace

Amen!



At The Service of the Sick

The address delivered by His Eminence Angelo Cardinal Sodano Secretary of State for the Blessing of the new Hemodialysis Service at the Surgery Clinic of the University of the Sacred Heart Rome on March 13 1991

1. Distinguished Ladies and Gentlemen, at all times, but particularly at a moment and in an environment such as this, the image of Jesus surrounded and nearly besieged by the sick profoundly touches us. The Gospel scene takes on an emblematic value: we catch a glimpse therein of all those who, over the course of the centuries, following Christ's example, have devoted themselves to the care of the sick, doing their utmost with all available means to relieve their suffering and foster their return to full health as far as possible.

Into this noble tradition of generous service to the sick person the Agostino Gemelli University Polyclinic was incorporated almost thirty years ago, seeking out top-notch professionals and equipping itself with the latest treatment facilities. Among these, the Hemodialysis Service of the Institute for Clinical Practice in Surgery—which since 1967 has been performing its work in the context of an integrated program of dialysis and transplants—certainly occupies a leading place. The desire to go on improving service in the light of scientific and technological advances has led to the present reorganization which we are inaugurating today.

I gladly take this opportunity to express my sincere appreciation to all who have con-

tributed to the realization of this highly specialized service and to all who devote the energies of their minds and hearts to it. A new tessera has come to be introduced into that complex, articulated mosaic of health facilities which is a modern hospital, and a further element is added to embody what Father Gemelli described as "the dream of my soul."

A Vision of Faith

2. This reference to the Founder of the Catholic University alone suffices to call forth the inspiring idea which held sway over the start of an enterprise destined to undergo such gratifying development. The Faculty of Medicine and Surgery—with the health facilities constituting its annex—was desired, according to the explicit statement by the great Franciscan, to train doctors who, "possessed of a soul educated in the observance of the norms dictated by Catholicism, will see a brother to be helped in the sick person." You are quite familiar with the lapidary phrasing with which he specified his thought: "*The doctor exercises a priesthood,* inasmuch as his work can have a great influence upon the soul as well."

Distinguished Ladies and Gentlemen, here we have an indication of what is "specific" to the Gemelli Polyclinic and to each of its facilities: a *Christian connotation*. The efficiency of services, the functionality of the wards, the adequacy of equipment, and the competence of the personnel itself do not alone suffice to meet the expectations of those entering this university facility to be cared for. The patient expects to find here, in the health personnel coming into contact with him, men and women who will be able to bend over him with the delicacy, understanding, and love which only faith in Christ can prompt.

This theme takes on special relevance in the treatment of persons suffering from chronic renal insufficiency: the periodic nature of therapy, the conditioning of the schedule, dietary prescriptions, and, above all, dependence on a machine can determine situations of psychological frustration in the patient which are not easy to overcome. A human relationship of openness and trust must be established with him which will stimulate renewed interest in life, fostering his will to make the most of what life continues to offer.

And who better than a Christian can be a *witness to hope* alongside those who suffer! Just before we heard the words of the apostle Paul, who opened out before us the boundless horizons of a sort of *cosmic expectation*—that of creation itself, which throbs with the hope of being "liberated from the slavery of corruption, to share in the freedom of the glory of the children of God" (*Rm* 8:21).

The doctor, in particular, who each day is placed by his profession up against the multiform fragility of the human body—St. Paul would say, "with its corruptibility"—can grasp in depth the truth of that longing: "We moan inwardly, awaiting adoption as children, the redemption of our bodies" (*Rm* 8:23). Isn't the *plus* proper to the *Christian* doctor delineated here? He, like every colleague of his, undertakes to bring the patient's sick body back to health, but at the same time is able to orient his gaze beyond the precariousness of all exclusively human therapy; he is able to invite the patient to look towards that definitive "redemption" of the body which God reserves for those who "possess the first fruits of the Spirit" (*Rm* 8:23) and turn to Him with the "inexpressible moans" (*Rm* 8:26) which He prompts in their hearts.

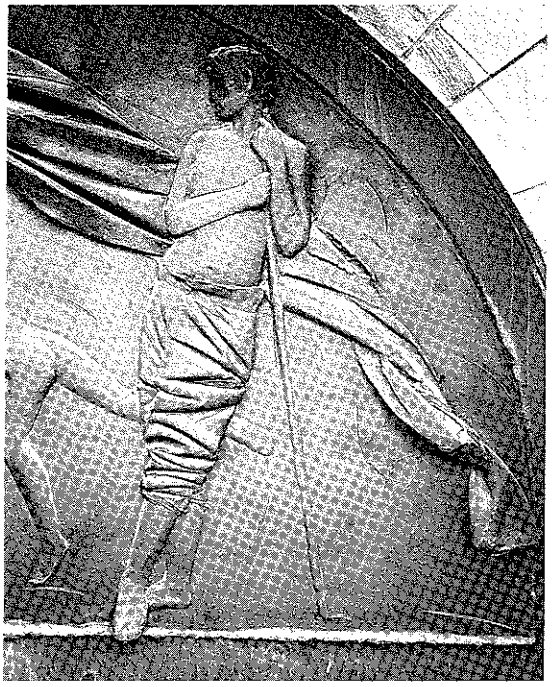
An Additional Serenity

3. Dearly beloved! People commonly talk of the medical profession as a *mission*. In the light of faith the expression loses all trace of conventionality and becomes enriched with singularly suggestive, fruitful content. Father Gemelli's assertion that "the doctor exercises a priesthood" reveals itself to be fully justified and lets us glimpse decidedly binding deontological implications.

May the patients entering this Unit—and every other ward of the Polyclinic—find at their side people who, in carrying out their respective duties, manage to bear witness in their words and actions to a faith which truly appears as a "foundation of the things which are hoped for and a proof of those which are not seen" (*Heb* 11:1).

To those who must measure their strength with illness and the physical and psychological distress deriving therefrom, it will then be easier to believe with St. Paul that "the sufferings of the present moment are not to be compared to the future glory which is to be revealed in us" (*Rm* 8:18). And the "additional serenity" which such a prospect constantly nourishes will not fail to make its beneficial influence felt on the very course of treatment, which can thus obtain optimum results.

This is my wish, which I accompany with prayer.



Jesus Is Health

Message of the Spanish Bishops' Pastoral Commission for Patients' Day, May 5 1991

1. We observe with joy that the celebration of Patients' Day in our local churches is meeting with growing acceptance. The topic selected for this year's Patients' Day ("Jesus Is Health") aims to help faithful Christians to reflect on the meaning of health in the light of their faith in Jesus Christ and to participate in the evangelizing mission of the Church as bearers of health and servants of life.

Health Today

2. Health is one of the basic goods of the human being and represents one of his insuppressible aspirations. In our society of well-being we are witnessing contradictory attitudes as regards health: strength and physical health are exalted and mythicized, and psychic, mental, and spiritual health are forgotten; imposing resources and efforts are devoted to safeguarding and recovering health while we gamble with it irresponsibly by engaging in and promoting a lifestyle which is scarcely healthy: a tumultuous existence, a lack of communication, smoking, drugs, alcohol, road accidents, consumerism, pollution, and so forth. We can rely on pharmaceuticals and sophisticated hospitals, and perhaps precisely for this reason we depend on them increasingly, feeling less responsible for our own health.

Jesus and Health

3. The Church, in drawing inspiration from and remaining faithful to Jesus, finds herself having to face the challenge of evangelizing this search for health, which is so intense and ambiguous.

Jesus did not address health as a separate question; however, his person, healing actions, gestures, words—his whole activity and life—are healthy: that is, they irradiate and promote the health of the human being and the community. Jesus emits health by loving, by freeing persons from what oppresses them, restoring peace and harmony to their lives and favoring a more humane and fraternal life in community.

Jesus invites us to live our health *in a healthy fashion,* as a gift of God which we must put to interest and look after, and not as an absolute good to which to subordinate everything. Health is for man, not man for health. To consume and lose health in the service of the Gospel is also a healthy way to

live out our health. Jesus sacrificed his on the cross as a supreme expression of his faithfulness to God and love for others, and salvation issued forth therefrom. Jesus invites and helps us to live through all existential realities *healthily,* including those which are painful and adverse, such as illness. Jesus is health, and to follow Him is one of the healthiest and most gratifying ways to live

The Church and Health

4. The Church is called today to implement an incalculably valuable service to the health of individuals and society. To this end, it relies on resources which are a fount of health: the person, the message and healing presence of Jesus; the vivifying force of the Spirit, the Word which enlightens and gives meaning; prayer and the sacraments, which open to the healing experience of encounter with God; her communities, which are places for an encounter between the sick and the healthy and provide a space for freedom and solidarity; her own healthcare, charitable, and educational institutions; and all her faithful, who live out the salvific values of the Gospel

Our Task and Collaboration in the Field of Health

5. The Church's Christian communities, apostolic movements, healthcare and educational institutions, and all of us Christians must specify what our task and form of collaboration are in this field. To this end, we propose the following indications:

- To educate ourselves and others to live our health as a gift and a daily responsibility in our own sight and in that of the community.
- To demonstrate that it is healthy to believe, hope, love, live as creatures, trust in God, thank Him, and praise Him, to be joyful and at peace with oneself, others, nature, and God, the first source of life and health.
- To promote integral health open to full salvation, to which man is called from the depth of his being.
- To liberate ourselves and help others to liberate themselves from attitudes detrimental to health, such as the abuse of tobacco, alcohol, and other drugs, violence, social-climbing rivalry, reckless driving, a consumption mentality, and so forth.
- To collaborate with initiatives and programs fostering a healthy life, such as the fight for an adequate environment and for healthy living conditions for all, the creation of fitting and humane structures, care of the body and the spirit, the cultivation of authentic, cordial relationships and habits suitable for the use of free time.
- To participate in the development of the most underdeveloped societies and make a commitment to obtaining a just international order which will make real peace possible.
- To be close to the sick to revive in them the desire to live, to help them discover the meaning of their illness, to fight and live with it, and, when the occasion arises, to accept an incurable malady in a serene and Christian fashion.
- To heal the physical and moral wounds provoked by social calamities of all kinds: wars, terrorism, aggressions ..

6. May the celebration of Patients' Day revive in believers a respect for and appreciation of their health and that of others and spur the Christian communities to be *places of health* for all in the midst of society and, in a special way, for the sick and the needy. May the intercession of Mary, Health of the Sick, aid us in this

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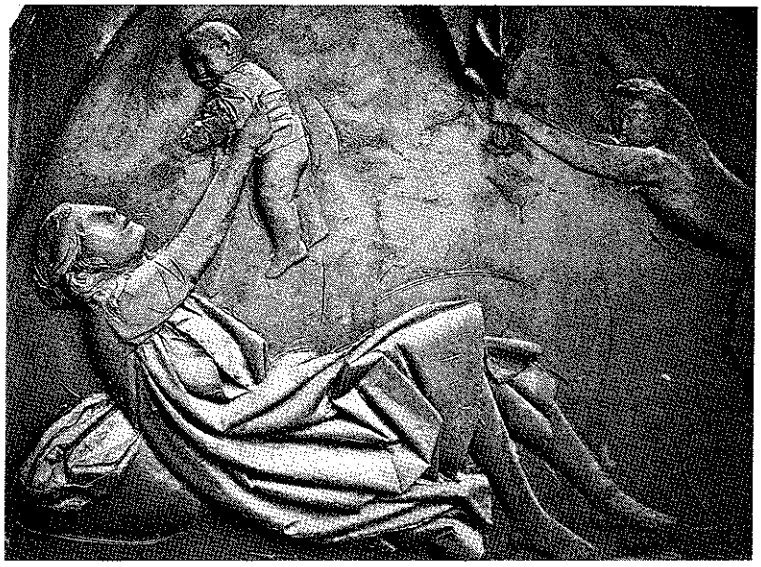
Topics

National and International Aspects of Health Development in the Next Decade

The "Chronic" Psychiatric Patient

Psychiatric Hospitals and Psychorehabilitation

Hopes for a Better Hospital in the Nineties



National and International Aspects of Health Development in the Next Decade

A statement by the Most Rev. Justo Mullor García, Head of the Delegation of the Holy See at the Forty-Third Session of the World Health Assembly, May 1990

1. The Executive Council of WHO has expressed its wish that particular attention be paid to "national and international aspects of health development in the next decade" during the general debate

In the opinion of the Delegation of the Holy See, it is an opportune and wise proposal It is opportune because the decade which has just begun gives us a presentiment of the year 2000, when, from the perspective of the historic Alma Ata Conference, the ambitious project of "Health for All" should be fulfilled. This proposal is also wise. With the fall of the Berlin Wall and the progressive crumbling of the ideologies of many States —in Europe and the rest of the world—the year which has just ended has opened up new perspectives for all mankind. Wisdom, then, seems to counsel a freer and more reflective, deeper and more authentic examination of certain subjects—including that of health—which have undergone the influence of ideological pressure over the span of a few years

The health of individuals and collectivities, as is well known, may occupy a primordial or secondary, real or theoretical, place in political programs That depends a great deal on the idea which the "policy makers" formulate concerning man and his life in society. For some of them, man is the central point in action by the State, which should not be the master of the citizen, but his servant, a catalyzer of free wills and not an oppressor of initiative and progress For others, the State is instead that which forges man and his destiny. In both the first and the second group, those accepting the existence of a spirit capable of ennobling man's body by imposing ethical exigencies upon him with universal dimensions and those reducing man and his experience in the world to a material or materialistic adventure can still be distinguished. There are also people who, while believing in a personal ethic, seem to ignore its community dimensions and social value

2. According to my Delegation, *the decade which is beginning demands a prior moral obligation of all who make political decisions on health*. It is a question of asking about the practical consequences of the ideas sustaining their acts. It is a matter of accepting in all lucidity or rejecting—while taking responsibility for such rejection—the existence of a "human ecology." If we consider both man and his physical, social, and moral environment more closely and deeply, in certain cases they are seen to be no less attacked and threatened than the natural environment itself

The ideological confrontation which has been produced over the last forty years—which coincide with those which have witnessed the birth of WHO and its progressive unfolding—has undoubtedly influenced the pretension—always ambiguous and sometimes dangerous—of ignoring certain dimensions of many problems of physical, mental, and moral health This effort to ignore such problems has provoked others.

It is frequently repeated that medicine has progressed more in the last fifty years than in the preceding fifty centuries. Ancient diseases have been overcome forever; life expectancy has increased considerably; trans-

plants of vital organs form part of everyday experience; some types of cancer are even curable today in over half the cases; generalized hygiene constitutes a broad, solid barrier impeding the unfolding of the fatal power of many viruses; infant mortality has gone down to levels which some decades ago were unimaginable; penicillin has saved more human lives than many wars have wiped out.

But this luminous landscape is not devoid of shadows. Temptations towards the dehumanization of medicine, the oppressive gigantism of hospitals, the consumption of alienating drugs and the overconsumption of anxiety-reducing drugs, the rise of real social illnesses which destabilize the two major pillars of mankind's hope—i.e., youth and the family—serious ecological threats capable of causing irreparable harm to millions of people, the appearance of what has come to be called "the culture of death," along with an "omnipotence of the economy," with homicidal consequences, biological research sometimes devoid of wisdom and the necessary controls, the abyss existing between health programs in the planet's north and south, the rise of new epidemics and pandemics —one of which is AIDS—indeed constitute a dark, tragic side to progress.

These facts and many others force those responsible for health —those who have had the valor and clear-sightedness to project a program involving "health for all in the year 2000"—to promote lucid reflection free from set prejudices in this decade which is beginning. We must also acknowledge—to free ourselves from prejudices or correct them—those which have contributed to the appearance of so many new dangers for man, who, on approaching the third millennium, continues to grope between feeling proud about his scientific power and being afraid of his theoretical immediate destiny.

3. *The Catholic Church,* whose center of universal communion is the Holy See, *is present in the world of health through an extensive network of medical schools, hospitals, and healthcare facilities.* At these institutions, along with the sick they seek to cure or whose sufferings they try to alleviate, there are hundreds of thousands of doctors, men and women nurses, students, and volunteers desirous of serving their neighbors suffering from illness or varying handicaps. It would be superfluous to provide figures and statistics in this regard. None of those attending this Forty-Third World Health Assembly is unaware of the Catholic Church's dedication —similar to that of other Christian Churches—to men and women, children and old people who are in situations of difficulty. It is a tradition finding its source in the personal example of the Lord and Master, who has taught Christians a way to follow, a life to be led, a truth to be sought out and believed.

This active, effective presence encourages my Delegation to propose a more lucid commitment during the present decade, with the examination of the serious ethical problems posed by modern medicine. When ideologies appear to be attenuated and their blind force is growing weaker, it would be opportune for us to seek together the way to liberate science from its oppressions. Even when these are indirect, as frequently happens, they may be serious. When it has fallen into the trap of ideologies, in extreme cases medicine has, unfortunately, entered into the Nazi camps and psychiatric hospitals, in the caves of police practicing torture, and in the laboratories of witches' apprentices. Free from ideological conditioning, medicine must affirm itself in a clear, solid, and universal line of behavior. It should orient itself only by its own scientific objectives and the concern to serve man—the whole man and all men—while respecting his profound needs.

Precisely because it has progressed in such a spectacular, positive way, medicine, on the threshold of the third millennium, should seek the manner of being itself by all means. It should not be a political—or, even less, ideological—instrument. It should remain attentive to the weakest men, to real or potential patients, and draw away from the path of the powerful who idolize money and measure all progress and all kinds of human action in terms of money. It should be chosen as a vocation and not out of self-interest. While taking into account the complexity imposed by the interdependence between the economy and the other branches of national and international human activity, medicine should never be managed solely in accordance with economic criteria and never resemble—even remotely—a marketplace where the laws of supply and demand come into play.

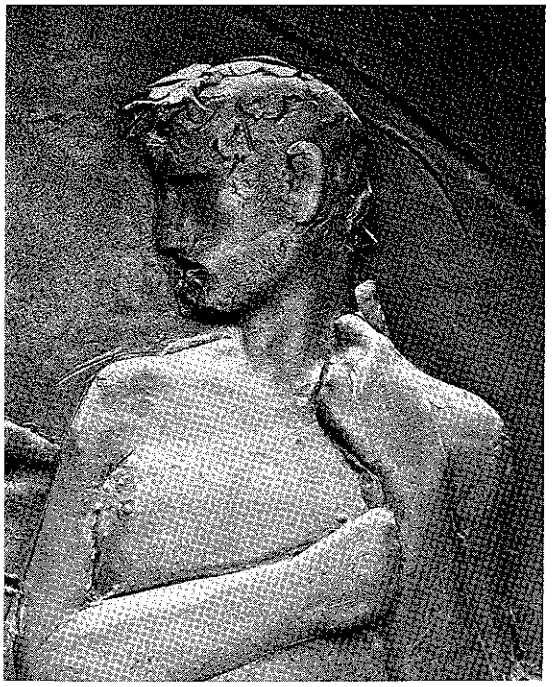
The noble end of "health for all from now until the year 2000"—or the finality which comes closest to this—will be achieved at the price of that deontological investigation. We shall otherwise run a great risk of seeing the serious problems already posed increase or perceiving other, even more threatening and complex ones appear.

4. The constitution of ethics committees in certain countries —which generally have a multidisciplinary character—represents a constructive approach and an initial response to these problems. But a new stimulus will be needed on a planet-wide scale—and, therefore, at WHO

headquarters—to create forums for reflection capable of providing stable, universal clues to a valid solution. In the Director-General's last Biennial Report there are signs of this will, which the Delegation of the Holy See would like to stimulate and support. But in such forums there must be a possibility that the voices of the developing world will be heard, for their needs are quite different from those of the countries at the forefront in the most advanced research. In some instances, the wisdom of the poor, rich in living, centuries-old traditions, can counteract the void created by spiraling research, whose greatest temptation is to detach itself from every humanistic, philosophical, or moral bond.

The reinforcement of these national organisms for ethics and the creation of interdisciplinary, international forums for medical reflection would constitute a rich contribution to approach the finality proposed by the "health for all by the year 2000" project. It is not a question of putting up with an annoyance, but rather of setting out—or continuing—on the straight path leading to harmonious development of medicine at the end of this century and —perhaps—of this period. It is a question of reinforcing the hope of a humanity called to free itself from all useless, humiliating suffering, while at the same time respecting the presence of pain in its history. It is also a matter of freeing ourselves from the fear that science—and, with it, medicine—will progressively reduce space for individual freedom. If this space were to be reduced, the hope of people with less of a chance to gain access to a level of physical and mental health close to that already enjoyed by a limited number of countries and, in extreme cases, groups belonging to a social elite would be diminished and weakened.

For our part, we are persuaded that only an ethical "recentering" can guarantee an equitable social dimension for medicine and the benefits it entails. To progress in this direction would signify doing a great service to the men and women of the year 2000.



The "Chronic" Psychiatric Patient

His Place in the Family, Society, and the Church

This approach to chronic psychiatric patients has been carried out with a view towards nearly 80% of such patients and of traditional psychiatric institutions, in addition to a considerable percentage of persons who try to enter or are directed to shelters, hospices, and asylums for the elderly.

It also deals with psychiatric patients living in huts (no one knows how many), with or without a family, on the streets, or under the bridges of large cities.

The concept of the chronic psychiatric patient has been eliminated by modern psychiatry. But are we not dealing with a fiction: In the following exposition we shall attempt to offer a pragmatic description of the various categories and to note lacunae and directions for the treatment and pastoral care of these patients in a nuanced and flexible manner.

What do psychiatry and pastoral care do for them:

1. The progress of psychiatry is undeniable

The scientific progress of psychiatry over the last fifty years is undeniable.

— The psychoactive drugs or psychic modifiers have constantly developed and obtained results. The family of psychotropic agents with long-term action is the latest thing in the area of mental health in recent years. Its results are evident.

— Hospital units have attained new dimensions which are more humanized, family-oriented, with the dynamics of sociotherapy and play, and greater effectiveness for the recovery of clients.

— Community mental health opened the hospital and experimented with numerous models of de-institutionalization, psychosocial rehabilitation, and reintegration into the family and profession.

— Some of the wealthier countries are creating—though sometimes hesitatingly and in the face of enormous resistance —"family" community residences or are attempting to place people in their homes.

Objectives

This evolution has reflected different criteria, some favorable to the integral well-being of psychiatric patients, others, unfortunately, elitist and harmful to

the well-being of certain types of patients

— The objective of curing, alleviating sufferings, and stabilizing personalities is present in most of the steps that have been taken.

— The humanization of patients' daily life, with greater normalization of the spaces and times of those assisted, is another praiseworthy objective which has been pursued—though not always attained.

— To provide patients with more socioeconomic independence and the satisfaction of self-sufficiency and independence constitutes one goal to be reached through these efforts.

— In the midst of the various changes and beyond the question of a possible cure, there is an implicit purpose of fostering in the patient in positive fashion his own image, his self-concept, and self-esteem—in a word, to give him an individual, family, and social identity, valued as an integral part of his health.

2. Limitations: Those Remaining Marginalized

In spite of everything, there are limits to this progress.

The intention of reinforcing the patient's feelings of identity —wounded by his illness, isolation in the hospital, and marginalization due to the social stigma and the loss of the family—is sometimes impeded by political and economic criteria.

Some models of de-institutionalization in fact touch the limits of dehumanization, focusing on economic, political, and professional reasons of their promoters instead of providing an adequate response to the real needs of those under care.

So-called long-term patients are the least adequately cared for in the context of some progress and new models Psychiatric patients with profound deficiencies are left on the fringe of humanizing advances.

To evaluate the patients' situation better in the current transition from the traditional model for care—closed and prolonged—to the open model of full reintegration into the family and society after cure, we should pause for a moment.

Some pragmatic definitions of the "chronic" psychiatric patient —or the "long-term" patient, as he is generally called euphemistically—can help us to analyze and comprehend the situations experienced by so many of them.

3. Who Are the Chronic Patients?

It is not enough to say that psychiatric patients are affected by hereditary deficiencies, disturbed development, or acute crises.

Analysis starting from social systems and subsystems in which the chronically ill are *included* or from which they are *excluded* leads us to a rather depressing panorama. Let us look at the profile of numerous groups of chronic patients who are cared for or who lack care.

They are separated, marginalized, or rejected as regards the mainstream of societies, Christian communities, families, and professions by frequently insurmountable barriers All of them —some more than others—could receive better and more humane care, along with a cure or complete rehabilitation

Social coordinates may help us to understand their sufferings —and so often those of their relatives and even the people caring for them—and gain orientation in the twists and turns of numerous complex social factors affecting integral well-being and each patient's sense of his own dignity within society and Christian communities.

Without denying organic and psychological factors, it is important to take into account the following situations if we wish to discern who chronic patients are and their real condition:

— whether one has one's own family, either natural or adoptive;
— group membership in terms of education, formation, and culture;
— group membership in terms of profession and occupation;
— leisure time grouping;
— Church or religious affiliation;
— other groups associated with readaptation and belonging;

Let us characterize these situations more clearly

The processes of categorizing and social comparison are useful instruments to evaluate the type of individual and social identity which society and the Church provide for chronic patients.

The profile of the chronic patient for this analytical model is socially disfigured by the following traits:

— they are the victims of conceptual and institutional exclusion from normal, valued social categories;
— they are placed into permanent, negative social categories, institutions, and identities as a result of excessive stress on the differences they present;
— a devalued, inferior social identity is attributed to them, as if they had no rights or duties;
— this devalued, negative social identity is reinforced through "abnormalized," standardized, and "ghetto-ized" institutions;
— the "diminished" social identity attributed to these patients is progressively interiorized by them and destroys them from within;
— instead of fostering an increase in self-esteem, this progressively reduces it

Pragmatic Definitions

In defining them pragmatically we show that the patients are situated in social systems and subsystems which are hardly desirable and in no way favor self-esteem and respect for their dignity

Unfortunately, these are the real systems and categories in which they are classified socially And their state and suffering over the lack of sensitivity to and understanding of their real problems may thus grow even worse

Let us look at some examples.

— Chronic pyschiatric patients have often been born with hereditary factors or deficiencies which disturb their functioning not only in times of crisis, but throughout their lives, rendering their social recovery difficult or impossible in terms of the models conceived for acute or mildly disturbed patients

— The most seriously and profoundly ill patients are, moreover, a challenge and "humiliation" for the progress of psychiatry, which tends to abandon them to avoid the unpleasantness of humiliation.

— There are patients who have developed in a disturbed way since childhood, without there being obvious family factors as a cause; and that disturbance remains in a permanent manner

— Maladjusted adolescence and youth have been for others a source of suffering for both themselves and their parents, whose wounds endure

— A certain number of them have gone through sporadic or repeated episodes of juvenile or adult delinquency, which makes family members victims of that trauma, drawing upon them the social milieu's rejection and hostility

— A lack of adaptation to family, social, and professional life in normal groups is rather frequent in the young and tends to be maintained over the course of life in many adults in that category

— The experience of one or several forms of dependence—alcohol, drugs, psychopharmaceuticals, tobacco, or other toxic products—characterizes the habitual behavior of quite a few of them These forms of dependence are generally a source of great suffering for the family group

— A smaller group lives in a state of judicial interdiction because of its inability to control itself and is sometimes deprived of the possession and use of its goods by relatives and neighbors for this reason.

— Among these patients there is always a large number without any family of origin, as a result of deaths, breaks, the divorce of parents, and so forth—a feeling of emptiness and abandonment is thus produced in them.

— Most do not have a family of their own—they either never did or lost it during prolonged hospitalization, through divorce, steps taken by a spouse, or simple abandonment. As a general rule, the chronically ill tend to be single.

— The number of those left alone after the death of their fathers or mothers—single or abandoned—is equally significant The loneliness of all of these people is mitigated only by companions, professionals, or volunteers at the facility caring for them

— As a result of early deficiencies and disturbances there is a predominance of chronic patients whose elementary and secondary studies are nonexistent or incomplete. At chronic-oriented facilities those showing interest in printed material—books, periodicals, and so on—are a minority

— Their productive labor is also nonexistent or practically so They do not keep jobs, and a good many of them are disabled or have obtained early retirement

— We thus have two dependent groups: those depending on the family or helpers for their daily activities and those depending economically on their parents or society for their survival.

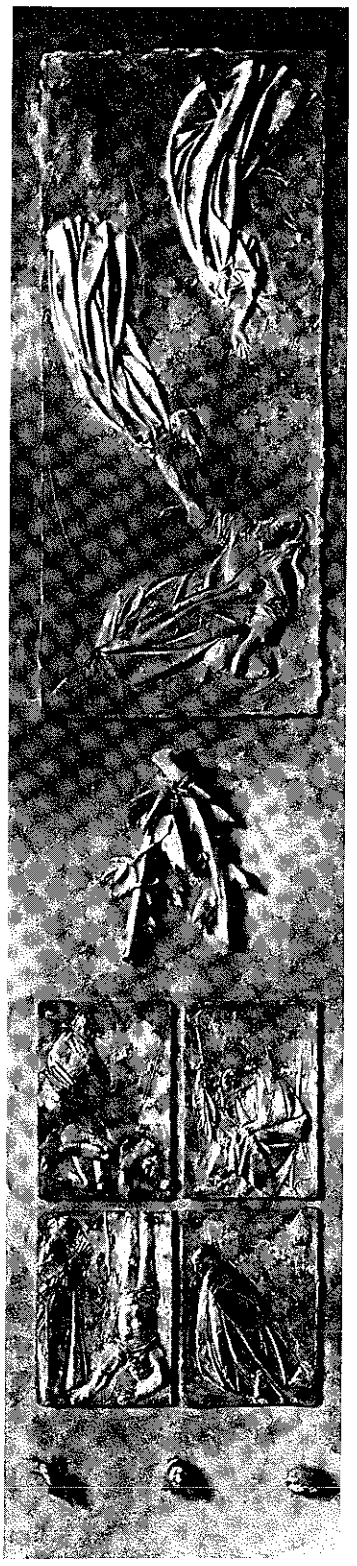
— Elderly psychiatric patients tend to increase in large numbers in industrialized countries and to be rejected by psychiatric hospitals which describe themselves as advanced and by families

— Not a few, before or during long periods of hospitalization have been victims of the spoliation of their possessions —inheritances, house, money, etc

— Deprived of physical and psychic health, they are reduced to the most extreme poverty by mass-production societies, for which they fall into the category of useless, abandoned beings.

— They undergo interior sufferings and those involving privation of products and commodities which industrial societies produce and promise them, thereby creating new needs whose satisfaction is, however, denied them by relegating them to the status of third-class citizens

— One sector of patients, in addition to other forms of dependence, has become dependent on begging and devotes itself to it whenever the doors are opened.



— Economically-minded technocrats reserve the crumbs of their budgets for them or entrust their care to institutions of social solidarity which are later given insufficient financial support and regarded as retrograde by extremist instigators of de-institutionalization

— As for the ecclesiastical domain, these seriously ill chronic patients are rarely selected as a topic for theological research at universities in relation to their salvation. Theological theories are worked out most frequently in such a way as to ignore them or even exclude them from the salvific presuppositions which insist on the levels of knowledge and personal freedom of those who are normal.

4. The Families of Chronic Mental Patients

Seen from the standpoint of the patients themselves, of society, and of the facilities caring for them, these families reflect some of the following characteristics:

— People are absent or simply do not exist. Sometimes a father has not been known by a son or a daughter. The mother may have disappeared or fought to the point of exhaustion for the health of a son or daughter.

— Most of the time the families involve two people: mother-son or mother-daughter. Some mothers have entered into symbiosis with their children until the latter's puberty and have afterwards abandoned the son or daughter in an institution as a result of ambivalent or aggressive relations, visiting the offspring assiduously, rarely, or almost never.

— Some families of the chronically ill, after abandonment or divorce, the interdiction of the sick relative, and the spoliation of his possessions, disappear, either changing their address or leaving a false one.

— Among family members there is frequently someone who keeps up stable ties with the patient, visiting him and showing an interest in the solitary relative.

— The relatives of the chronically ill—even those who have been partially resocialized—generally resist the technical proposal of resocialization, out of fear of possible aggression by the patient, expenses related to him, or even because of a lack of space for him in their little family apartment in the city. From their own standpoint, these families are marked by suffering.

— There are parents suffering from "chronic" anguish over a son or daughter who is retarded, disturbed, or mentally ill. Those who are better off economically try everything to obtain a cure, improvements, or rehabilitation for their child. Those less well off add to their sorrow over the child's deficiency or disturbance their anguish over finding him a lifetime place in a caring institution warranting their full confidence.

— Families that are more sensitive to their relative's ailment become anxious over the fate of their loved one as the years go by, worrying about what may happen to him when they are no longer there. They strive to create safe endowments with their own possessions to ensure care for the patient after their death.

— There are families that do not visit their patients or do so only secretly, either out of shame in the sight of their neighbors or in order not to frighten their children or grandchildren with the awareness that there is a psychiatric patient in the family.

— Others have permanently stopped visiting them because on one occasion—the last—they found the patient in the midst of an aggressive crisis and the memory of that experience has been traumatizing and paralyzing for their relations with the patient.

— Today, with the currents of community de-instituzionalization, many families undergo panic over the alternatives of having their sick relative at home or on the street, in a crisis state, without care, the object of ridicule or in danger of a premature death. Even the prospect of seeing them at a protected residence sometimes frightens them.

— Some Christian parents are distressed because churches, pastors, and Christian communities do not know what they should do with their sons or daughters in the church; others ask themselves—without receiving authoritative responses—why their mentally deficient or psychically ill children or relatives who assiduously attend Mass are not accepted by certain priests for the sacrament of Communion.

5. Social Subsystems Related to the Chronically Ill

The panorama of the relational dynamics among family, psychiatric, social, and governmental subsystems referring to the chronically ill can help us to comprehend patients' and relatives' experiences in greater depth.

— The main subsystems for chronic patients are families, experts, and public or private services.

— The disturbed—dependent and passive—adapt to the hospital facility, from which they do not wish to go out and spontaneously ally themselves with relatives, who also resist any change in the *status quo*. The relatives are thus relieved of possible uncomfortable experiences in the home, the burden of additional housing and food expenses, and so forth. Some of these families even manage—without any responsibilities—to enjoy use of part of the annuities of those patients who have them.

— When certain patients become stabilized and doctors propose their leaving the hospital, families seek to ally themselves with the sick and other experts to oppose their leaving the hospital. Then a triangle is formed, two of whose angles—family and patients—for different reasons resist the professionals most sensitive to the currents of community psychiatry.

— When professionals insist on the decision to de-institutionalize, the family sometimes disappears, leaving a false address, and the patient—if sent outside the hospital—is left alone with his own means, limitations, and suffering. The first crisis will come upon him in the street as he seeks the soup of the poor and night shelters—that is, if he is not forced to sleep in the street or under bridges.

— In spite of pressure exerted by de-institutionalizing currents and neoliberal economics in the

healthcare field, some professionals feel that such currents are not justified in the case of many chronic patients and join with the patient and family subsystems. Instead of de-institutionalization, they defend the transformation and humanization of the spatiotemporal realm of the old psychiatric facilities; but, since such a measure demands expenditures, changes are indefinitely postponed.

— Government health officials are, moreover, divided between the old systems of public services for all psychiatric patients and their being broken down into home, residential subsystems, whether private or public. In spite of everything, they largely exclude from their concerns the most seriously ill patients, who are hard to maintain in residences, hoping that Church-run institutions will solve the problem as best they can, virtually without means.

6. A Wounded, Negative Identity

The categories in which they are classified and the subsystems they are pushed into contribute to these patients' acquiring a supplementary negative identity, above and beyond their ailments and limitations.

— The abandonment to which their father, mother, husband, wife, or children handed them over makes their life embittered and solitary. They feel alone and utterly worthless.

— The state of dependency in which they have become accustomed to living at home and in institutions makes them partially or completely dependent, in need of permanent care and company.

— The barriers created—fixed or rigid, raised up at times by categories and subsystems within which society always tends to enclose chronic psychiatric patients—impose upon them an ever-poorer image. They feel like society's insignificant members.

— The absence of their family and of permanent friends, in turn, provokes in them the supplementary loneliness which is added on to their illness. And, once again, it is their companions in illness and at the facility or residence who relieve this loneliness.

— The prevailing or exclusive kind of relationship with health personnel, specialists or auxiliaries, tends to make them feel sicker and more dependent on those to whom they know they can turn for support.

— Daily life at installations and numerous groups in which they rarely appear with their own name, are treated as simple pathological entities, and have to submit to a disciplinary routine, without sufficiently personalized relationships, accentuates their feelings of inferiority and low self-worth.

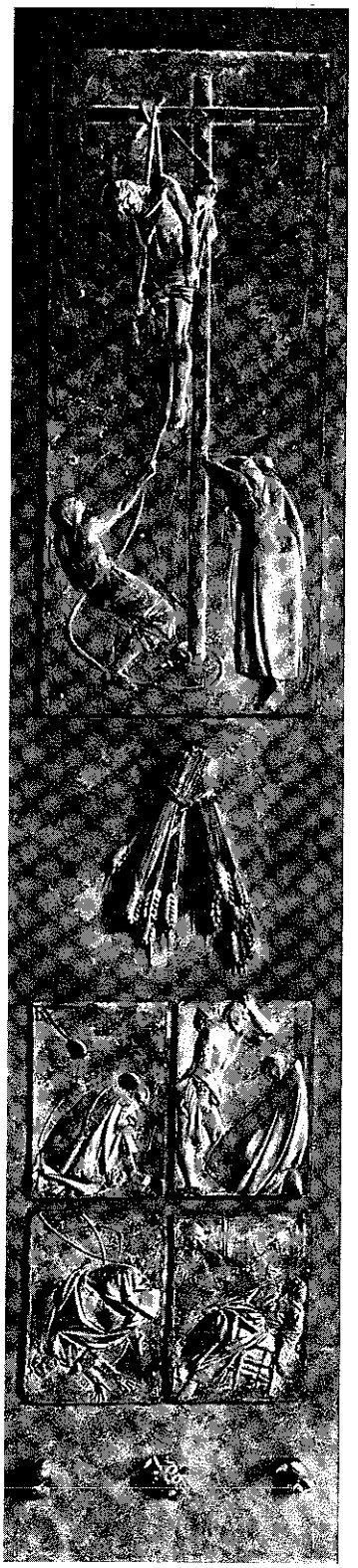
— The failures of repeated crises and unsuccessful attempts at social reintegration reduce their hope and will to struggle.

— The long years of hospitalization—sometimes more than thirty—are added to illness, "institutional neurosis" or chronic dependency, and an inability to react in urban environments. They feel unable to go out, travel, use money—to live independently. And the less they do so, the less able they are to and the more inferior they feel.

— They thus progressively interiorize a negative, inferior image of themselves which makes them feel incapable of everything, wretched, contemptible, unworthy of being esteemed. They are, in fact, the poorest of the poor.

7. It Is Not Enough to Speak of Psychiatric Patients

It is clear that psychiatric models structured to respond to situations and needs of acute psychiatric patients, rehabilitate them, and reintegrate them into open society, when applied to many of the chronic patients we have just described, turn into a source of great suffering and dehumanization. Such models rarely take into account all the real situations of the sick in chronic biosocial conditions, much less those who suffer serious limitations. When psychia-



tric patients are discussed, it is imperative to ask, "Which"?

The models of scientific progress may, through psychotropic drugs, suppress pathological symptoms, but they leave intact biological, mental, spiritual, familial, and economic deficiencies. Psychopharmaceuticals suppress symptoms, but do not increase values

Some currents of psychiatric rehabilitation come to a halt and desist in the face of these patients when they find that the complete rehabilitation and social reintegration they would wish for are not viable, and they abandon them to their malady and poverty.

What is left for these patients, in many cases well known, who exist in all the large cities of the so-called progressive world?

It hurts to say so, but for many who leave care facilities there remain only garden benches, bridges, and cardboard boxes to spend the night. The most "fortunate" ones find a place on the platforms of subway and train stations, in night shelters, and asylums

Alcohol, prostitution, cruelty, delinquency, and utter degradation constitute the fate of the most unfortunate, many of whom commit suicide or are robbed and attacked until being killed

Am I exaggerating? If only I were The large European and American cities are each day the setting for many of these human dramas They are sometimes dramas of suffering for the sick themselves, for their relatives, and for the admissions services at care facilities, hospitals, shelters, homes, Catholic Charities centers, and other similar institutions, which cannot respond to so many situations of affliction

8. What Can Be Done?

In practice, the chronic psychiatric patient is not mainly or exclusively a person in need of psychopharmaceuticals, psychiatry, nursing, psychology, or a clinic in which to be examined on a weekly or biweekly basis and sent back home.

After such an exam, he does not return to his family or home (which he does not have), as some currents in psychiatry propose for acute patients. It is frequently a case of a patient without a family who is unable to have one or to be accepted by it; he lacks a home, a room, or a shelter and is without food, clothing, and a place of his own He has nowhere to rest his head.

What good does the "miracle" of psychopharmaceuticals do them, or modern psychiatric hospitals and services at general hospitals, with dynamic teams exclusively devoted to acute patients? They all reject them, as do families and societies

What sometimes hurts most is the fact that some psychiatric hospitals reject them in the name of false scientific progress, giving them no care other than a piece of paper with writing on it and some words spoken—or the street and urban holes

What advantage is offered to them—even in the very projects for normalized residences—if neither governments nor social welfare institutions deal with the thousands of cases in each region? And sometimes, as a result of their state, there is no place for them in either a traditional facility—now occupied or suppressed—or those alternative homes or residences, which are still nonexistent or insufficient

Is it worthwhile to speak of protected workshops if they are insufficient or inadequate for 30 or 40% of these patients? They would lack both the character and the capacity for the occupations offered to them there.

And would large-scale, standardized psychiatric hospitals be a solution, inherited as they are from the past century, so often dehumanized and not always with sufficient places for many of these needy patients?

* * *

We have not posed the preceding questions out of pessimism or a taste for creating problems. The problems of a great many chronic psychiatric patients and their families are painful and require responses more in keeping with reality.

Many continue to need integrated and flexible solutions involving:

— possible rehabilitation;

— reintegration into the family and the home;

— a new, stable rootedness in their culture and territory;

— a new occupation suited to their state.

But their most serious deficiencies concern:

— *redignification* and humanization of their whole personality;

— human and spiritual *revaluation* in response to their deep need for self-esteem, to which even the most seriously disturbed are sensitive;

— *taking responsibility*, in the measure of their capacity, as the subjects of rights and duties;

— *recategorization* or transcategorization in social life which will place them in categories of social belonging that are positive and dignified;

— *re-identification* or transmutation of their self-concept and identity, with social attribution and personal interiorization of meaning enabling them to grow within their limitations;

— *ecclesial re-theologization* through innovative theological reflection and educational pastoral care regarding them, their families, and those caring for them as those for whom theological reflection and integration into Christian communities are rightfully meant;

— *creative rediscovery* of the fact that, in spite of their limitations, they will be capable of a valid, mysterious relationship with God, who loves them

Adequate rehabilitation for these patients is sometimes not very much at all, from the standpoint of professional and social reintegration, but it is a great deal from the standpoint of acceptance and offering a daily life which is humane and dignified

Readaptation to and taking up residence with one's own family is not possible in many in-

stances, but the adoptive family or stable group to which one belongs, in an equally stable dwelling, inside or outside the hospital, can take the place of the family and give the patient feelings of security with respect to his companions, the future, and the shelter of a place to live. He feels he has a territory of his own.

This is what many do not find on being constantly placed inside or outside facilities, sometimes more as a result of objective economic and statistical criteria than technical-scientific and humanitarian criteria. They are turned into a plaything of fashion and rejected by different types of institutions without knowing what the "territory" they have a right to is.

In every country, the Church —theologians, pastoral workers, and Christian communities—cannot continue to be absent from the responses provided to these least ones in the Kingdom of God. It is not enough to hope that some Orders and religious Congregations will take care of them with love and dedication, according to their own charisma.

It is not enough for secretariats and commissions to organize theological and pastoral weeks on subjects aimed at society's "well-to-do" and the Church's "leaders." These patients, the least ones, in their serious mutism, from a lack of health and of a voice to speak out with, now await the coming of the Kingdom of God and the beginning of the fulfillment of Jesus' words: "Let the children come to me."

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Psychiatric Hospitals and Psychorehabilitation

The history of Italian psychiatric institutions, after the break produced by Law No. 180 of 1978, now seems permeated with awareness of the need to create increasingly humane, personalized services for different needs of patients. In the battle which has had to be fought—and is still being fought—to get the patient's centrality accepted, the St. John of God Brothers' facilities should be pointed to on the front lines (especially Sacred Heart in Brescia). To these we owe a basic change in the perspective which has prevailed until now—the shift from the institution as a place for therapy and control alone to its being conceived as a facility meant for rehabilitation.

The 1978 norms established a new principle: hospitalization was to be arranged for only when there was therapy to be applied which was sufficiently urgent to require a stay as a condition. The law thus asserted that the psychiatric problematic was to be managed mainly outside the model of hospital involvement, giving the professionals concerned (and particularly the Regions, to which legislative authority was attributed in the sector of psychiatric attention) the responsibility of creating a local network for care. Unfortunately, this has often been translated into turning patients' families into insane asylums, leaving them without support to deal with pathologies that, quite frequently, no one was able to respond to at that moment. An increase in local responsibility, according to statements by psychiatrists such as Petrella and Bezoari, was supposed to bring about a re-emergence of the patient, who had been wiped out and had disappeared in previous institutions. Their new integration—in view of the impact psychiatric illness might have on a technologically advanced society, in itself hostile to nonproductive members—was to be used for what was termed "real prevention" and a "consistent fight against marginalization." There was an attempt, that is, to build up a sensitivity leading to dialogue with those felt to be different—and not only the psychically distressed, but also the handicapped, the elderly, drug addicts, immigrants, and nomads: all those whom an evolving society like ours, constantly searching for happiness as expressed in increasingly material

terms, is continually led to expel More than ten years after Law 180, we must, however, state that psychiatric illness has not had that impact of re-education which was intended. Society, roused in its deepest fears, has responded by marginalizing and forgetting even more those who, left to their families and with little external support, have not managed to keep pace. No attention has been paid, then, to reminding people of madness by way of the patients—what even a minimal sociological study would easily have shown: every social structure seeks to perpetuate itself, eliminating or marginalizing all who are felt to be dangerous for its existence. Without mechanisms which we could describe as involving "social reassurance" (and at root for many centuries psychiatry performed no other function), the patient cannot be effectively re-integrated.

Psychiatric illness in fact comprehends manifestations which, on the one hand, may be regarded as imposed by society and, on the other, as intruding upon it. On the latter society bases its demands for protection and too often forgets that to prevent the antisocial acts sometimes linked to psychiatric illness, it is indispensable to rediscover the components which, in moving society, also regulate this conduct. As Kluckhohn says, "Knowledge of a culture makes it possible to foresee a good many actions by each person living in that culture." Our society is only apparently spurred by rational motivations. In reality, the emotional component is extremely marked, even more so at the present time, when the elements promoting group cohesion are diminishing. Riesman states, "We are heading towards technical communication—that is, impersonal, external, anonymous, and anodyne." And the emotional component in communication, the channel for a significant element in group cohesion, is, then, increasingly limited and controlled. To compensate for this, there is, accordingly, an ever greater push by the dominant group to externalize its aggressiveness by creating what I would term a virtually "physiological" belt of marginalization. In this way, the role of the psychiatric patient, understood to be deviant, tends to be constructed in terms of the actions expected of him, which take on an emotional weight for society far superior to their real value. Let it suffice to recall that, if we consider the antisocial acts committed each day, on a statistical basis we would have to say that they are the patrimony of healthy people. They are mostly committed out of socially acceptable motivations, though (desire for money, consumer goods, sex, and so on), and thus do not make a strong emotional impact. The psychiatric patient's action, on the other hand, impresses us for its apparent incomprehensibleness and unforeseeableness.

Society, then, has occasion to rediscover therein those "dark forces" upon which it can readily direct its aggressiveness, regaining group cohesion. Society thus needs to rediscover psychiatric illness through the mediation which psychiatric services have proved unable to carry out, having limited themselves to performing a function of control. Here action on the group into which there is reintegration (reawakening its elements of community and health) has a weight nearly equal to action on the psychically afflicted. Hence the importance of the work of renewal going on at the St. John of God Brothers' facilities in Italy. The Institute of the Sacred Heart in Brescia, in particular, is showing that there can be a new way to conduct psychiatry: without action which, in provoking society's alarm, creates additional marginalization, but recognizing in the case of the psychically ill all those human rights which no one should ever lose, even when ill. One becomes a resident at the institution—not just a patient—who is provided, above all, with stimuli towards psychorehabilitation, in addition to possible therapy. This forced us into profound reconsideration of the professional figures involved in terms of the new role they were gradually taking on, and also a notable restructuring of the environment. The coordination of this task was entrusted to Professor Ugo Formigoni, in charge of psychiatry in the State of Illinois, but better known for having worked for a long time with Bettelheim. In his steps to reorganize he has adopted Bill Anthony's definition of psychiatric rehabilitation—i.e., action aiming, on the one hand, at the development of man's potentialities and, on the other, at modifying the environment in such a way as to sustain them. In following the motto "Live, Learn, Work," certain structures have been reinvented where the patient, in an encouraging and facilitating atmosphere, may recover the capacity to learn. This is, in fact, a fundamental activity which pathology blocks quite readily, priming the mechanism of marginalization. In speaking of psychorehabilitation, we must, however, be clear about certain points (as Saraceno and Sternai stress):

— *Where* this program is to be implemented: the environment, indeed, must itself serve as a stimulus and support to make the most of the patient's personal capacities and permit his gradual reintegration (hence the need for differentiation in structures).

— *Who* is to be involved in this program: careful selection, with precise knowledge of the psychic components of those who will be worked with, is obviously important Rezzonico and Goldwurm speak, above all, of passive marginality, upon which effects can be had more readily.

— *When* to act: it appears preferable (Siciliani and Siani) to achieve pharmacological control of acute symptoms first of all

— *How* to act: a holistic vision of man is essential to achieve "better activation of personal, environmental, and relational resources for the purposes of reintegration and autonomy" (Rezzonico) Technique particularly concerns the modality of action together with professionals, patients, and their relatives. This enables us to promote varied relational abilities and achieve positive environmental maturation of the institution's "guest." In addition, work undoubtedly represents an element which, in this perspective, can facilitate individual autonomy Indeed, work, by leading one to learn how to apply effort in directing it towards an objective, increases the sense of personal esteem It also provides an individual with economic, social, and psychological support in the group he belongs to (Palmer), furnishing a role definition which diminishes aggressive responses to the psychiatric patient.

It seems natural, according to what we have stated, that there should be a need for multidisciplinary action capable of stimulating, as Professor Formigoni says, the three "essential qualities to facilitate change: competence, trust, and motivation." To this should be added the rediscovery of a social life which will confirm one's desire for cohesion with more vital communication on an emotional level, in contrast to the present variety (cold and anonymous) and the renunciation of the need to create marginalization to discharge every aggressive thrust externally. And this will contribute to people's living once again together among men

PIERO ROCCHINI, M D.

Hopes for a Better Hospital in the Nineties

At scientific, union, and health policy meetings there has frequently been talk of a new model for the hospital of the nineteen-nineties. Experts, government officials, programmers, economists, and health professionals have made contributions with a view towards an efficient, smoothly functioning, technically advanced, and not too expensive hospital. No one—or almost no one—has, however, advanced proposals aimed at the person who ought to be the beneficiary—the *patient*. He has no say in these debates, and few seek to interpret his real needs authentically. The patient would certainly not be very satisfied with the "new home" which is being prepared for him, not so much on account of its structural aspect as because the measure of the proposals advanced is purely technical, completely overlooking the real values of those who will be "accommodated" in these hospitals of the year 2000.

The patient, then, is not asking us for mere restoration of a jammed bureaucratic mechanism or purely technical correctives, but also, and above all, valid responses to the most significant ethical problems, such as his destiny and his life.

It is thus indispensable for a *proposal for humanization* to progress alongside "modernization" and more technical efficiency with just as much conviction and tenacity by creating a model for facilities not related to mere *ideology* or the result of philosophical debates, but representing a process of *restoration* of *our alliance with suffering man.*

We must have the courage to ask ourselves to the point of discomfort whether, in imagining the hospital of the coming decades, we are moved or not by the awareness that the basic need of every man is to be recognized as a person, with all his worth—i.e., worthy to receive attention, solicitude, and "love" above and beyond technical services.

The "human" project cannot in any way be disengaged or separated from the "hospital" project. And this is valid for all, whether or not they are Christians, for whoever is convinced of and works on the "human" project is Christian, even if he professes himself not to be one, just as whoever, though calling himself religious, does not work on that project is not a Christian, even if he says he is (Fr. Pierluigi Marchesi).

Current health culture is, however, largely dehumanizing because it excessively mystifies or technicalizes man's vital problems. If a sick man—who is for that reason experiencing the most fragile moment in his existence—goes into the hospital and remains a stranger, he automatically finds himself marginalized. If he is not received as an individual person, but as a "clinical case," he falls into the inanimate category of equipment, apparatuses, and objects.

The central place in the hospital does not correspond, as has sometimes been claimed, to doctors, administrators, nurses, or even religious, but to the patient.

But most often an intellectual and emotional barrier comes between the patient and ourselves, *convinced as we are that our professionalness suffices to solve all his problems.* And it is not just a question of a momentary or definitive loss of health, for to this is added a series of emotional and psychic tensions going from the loss of one's autonomy, from having to entrust oneself completely to strangers, to the absence—even if momentary—of the faces dear to one. Man thus lives through his illness in a unique way, tormented by a series of problems we often do not deal with. If our attention centers on his sick organ alone, we shall then be able to provide only technical responses which are valid, but insufficient.

This is the barrier separating us from the patient and threatening to reduce the therapeutic and technical value of the hospital, even of a sophisticated hospital.

I feel we can all bear witness to patients' disappointment, not only when they have become aware of structural deficiencies or our possible incompetence, but especially when they have discovered our lack of attention and humanity.

There is a risk that current barriers will become even more accentuated if we conceive of the hospital and care in the nineties only as a *high-technology and scientifically high-efficiency model.* We shall run the risk, then, of *confining the patient in an elegant, computerized waiting room* in which he will be able to hand over to the doctor and other health professionals his liver or his heart, stripping himself of his personal being as a subject and donning the pyjama of the clinical case.

To humanize the hospital does not mean, then, to add sophisticated equipment and very advanced technical means, but rather providing a good which man greatly needs—to be treated as a person. The hospital should thus accommodate man in his totality.

Everyone must, therefore, be trained to rediscover in that suffering man who entrusts himself to us at the most delicate moment in his life the values of the person in his totality and not just the pathological dimension.

It certainly does not suffice to reflect on the humanization of

the hospital—we must help one another to uncover and remove the obstacles impeding its realization. All of us—individual health professionals, unions, administrators, and government officials—must together identify the best ideas to achieve *authentic hospitality* for contemporary man in need of care at today's hospital—not just that of future years.

But unless all of us together are deeply convinced that the human person is the bearer of certain values which constitute him as an inviolable reality, we shall construct a very pretty frame for a faded, anonymous canvas of no value.

A hospital that is unable to provide adequate responses with respect for freedom, truth, and love has no right to call itself one. To be truly "humanized" the hospital must be open, *transparent*, in such a way that indolence, injustice, and inefficiency cannot be concealed. It should give priority to teamwork and the continuing training of all staff members so that personnel will be kept up-to-date and also aware of psychological and ethical aspects when encountering patients.

The challenges for today's programming decisions will be met in terms of values rather than technology.

We must recall that humanization is an act of justice and charity towards the sick—it is justice because it respects the right of man sanctioned by human laws; it is charity because it respects a need to receive attention which no law can regulate or impose.

But to humanize the hospital our humanization is needed on a priority basis; in order for it to change, the men working there must be changed and, therefore, trained.

What concrete proposals can improve the current system of care?

1 The Ethical Training of Personnel

a) on a university level: bioethics chairs

b) at nursing schools

c) within hospital facilities: continuing education

It is, first of all, indispensable to restore the dignity, functions, and responsibilities of individual health professionals which have been thoroughly subverted today. The results of purely bureaucratic, highly politicized management are obvious.

Alongside structural improvements, the men working in the health field must also be prepared in a manner different from that of the recent past and, therefore, trained in a school which associates ethical preparation with the technical variety.

At a university level, it is essential for students to be trained from an ethical standpoint as well, in addition to the scientific one.

Every professor should be convinced of this exigency; bioethics chairs are justified precisely in view of this purpose. At schools for professional nurses, the same effort is required in preparing motivated health workers directed towards a task which is increasingly difficult and exclusive in an area where training is not enough, but there must be a "sense of vocation."

2. Bioethics Committees

From ethics and, particularly, *bioethics*, we are expecting a decisive contribution to carry out the humanization of hospital and care facilities in concrete terms.

In a pluralistic society and in the absence of ethical guidelines reflecting unanimous opinion, a feasible approach may be that of Ethics Committees.

Experience in nations where this approach has been maturing for some time is decidedly positive. In the face of the most delicate decisions, which frequently bring with them profound disturbances in conscience (terminal patients, transplants, etc.), the possibility of resorting to *consultative advice* above the parties in question can surely offer serenity and tranquillity, fostering dialogue and understanding.

The Catholic Medical Association of Italy pursues and proposes a model for health professionals of a vocational and missionary kind which may be shared and practiced by all, though with different purposes (the exercise of charity by believers, perspectives of solidarity and justice among nonbelievers), for it is coupled with universal ethical values (among other things, they have been introduced into various recommendations by international bodies and into deontological codes).

The Association has been involved for years in the frontiers of ethics and bioethics and has organized training courses in this direction, identifying *Ethics Committees* as an instrument which can contribute to restoring a balance at health facilities that has been markedly compromised nowadays.

To humanize does not mean to be better, but to provide more integrated responses to the patient's needs.

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

Testimony

FIAMC

Christian Fraternity
of the Sick
and the Handicapped

Health Care Ministry in Peru

Bishop Canale

Spanish Health
Apostolate Plan

HIV Treatment in Rome

Health Ministry Statute
for Tuscany, Italy

The International Federation of Catholic Medical Associations

The Way to an International Federation

During the pontificate of Leo XIII, a French doctor, Le Bele, took the initiative of founding in his town of Mans the Association of St Luke, attracting Catholic doctors This was in 1884 and represented an immediate answer to the Papal appeal, expressed in the Encyclical *Humanum Genus*, to form Catholic professional organizations, as a way to implant Christian values and attitudes in the world of labor

Thus, from the beginning, a close relationship was established between the Magisterium and the work of Catholic Physicians' Associations.

A number of these associations were established in different countries during the next decades and soon the need was felt to coordinate national guilds on an international level A first step in that direction was the Secretariat of National Societies of Catholic Doctors, founded in Paris in 1924, under the patronage of Pius XI The Secretariat was a turntable, which played an important role as a documentation center, and in stimulating collaboration between national associations and in founding new guilds It also organized the first three international Congresses (the first was held in Brussels in 1935) During the 3rd Congress (Lisbon 1947) Dr Pasteau, President of the Secretariat, suggested that the office of an international organization of Catholic doctors should be in the Vatican and expressly named the Palazzo S Calisto This proved to be a real prophecy, because since 1987 the federation has had a permanent Secretariat exactly at that location. The legal and statutory birth of the Federation was the 11th International Congress (Manila 1966), when the General Assembly adopted statutes and by-laws which were approved by the Holy See Nowadays, the Federation is a truly worldwide organization, with six regions (Africa, Asia, Australia and New Zealand, Europe, North America and Latin America) and an organization in about forty countries Those countries in the European and Asian regions also have Federal Groups

Why does the Federation exist?

Some critical voices both inside and outside the Church never ceased to ask why there should be professional lay organizations in the framework of the ecclesiastical body The readers of this publication will certainly agree that in our times, when technico-medical and biological advances succeed each other at a very fast rate, an organization which has both professional credibility and sound doctrinal basis is utterly indispensable The Holy Father, John Paul II, stated in his address to the delegates of the Federation's 15th World Congress, held in Rome in 1982, "Collective, intelligent, well-planned, constant, and generous work is required, and not only within the individual countries, but also on an international scale Coordination on a worldwide level would, in fact, allow a better proclamation and a more effective defense of your faith, of your culture, of your Christian commitment in scientific research and in your profession."

We may say, without exaggeration, that this is the best explanation of the need for an organization like the Federation and that its aims are also perfectly outlined in this Papal message

The statutes define the aims of the Federation in the following order:

1 To coordinate the efforts of the national associations or guilds, helping to study and spread Christian principles throughout the world of medicine

2 To encourage and stimulate the formation of Catholic medical associations in all countries

3 To participate in the advancement and development of the medical profession and to promote health and social work in accordance with the Magisterium of the Church.

4 To offer a counselling service for the study of ethical problems in the practice of medicine and to find answers to the challenge of new technologies

The Activities of the Federation

In the tradition of its beginnings, the Federation organizes a World Congress every four years Since 1935, when the first Congress was held in Brussels,

many Congresses have taken place, all of them giving an opportunity to present papers, to discuss, to compare different approaches and views and to try to find solutions for technico-ethical problems which correspond to the real needs of man and are faithful to the Gospel and to the teaching of the Church. Each Congress has a main theme and it is not surprising to find among the themes selected in the recent Congresses such important issues as "World Population" (Manila 1966), "Conservation of Life" (Washington 1970), "Freedom of the Children of God" (Barcelona 1974), "Quality of Life in a Changing Society" (Bombay 1978), "The Physician in the Service of Life" (Rome 1982), "Progress in Medicine and Respect for Human Life" (Buenos Aires 1986). The 17th World Congress will take place this very year, in Bonn (September 14-18) and its theme is "The Biological Nature and Dignity of the Human Person."

Besides giving origin to important publications (most of the proceedings of the Congresses have been published), these international meetings offer an ideal setting for the encounter of Catholic doctors from very different areas of the world, where general problems may be affected by local conditions, related to the sociocultural ambiance of the respective regions. Congresses regularly organized by the European and the Asian regions also take place every four years, separated by two years from the World Congress. These international meetings represent the most valid contribution to the study, discussion, and diffusion of Catholic medical thought in the world, formulated mainly by Catholic physicians who are knowledgeable and up-to-date in their field

Another important activity is that of sponsoring meetings dealing with new issues in the field of medical ethics These meetings are organized in the years in which no World Congress takes place and help to bridge this period They cover matters which have emerged recently and represent new challenges to the Catholic physician The last two conferences were held in New York (1988) and Coimbra, Portugal (1989) and dealt, respectively, with the problems of the AIDS patient and with ethics in medical genetics New York was an obvious choice for an international conference focused on ethical, religious, political, and social implications of the disease, since the Archdiocese of New York has developed, since 1985, a comprehensive programme to provide health care, spiritual assistance, and other services to the AIDS victims. Cardinal O'Connor, on whose intiative a leading role of the Archdiocese in hospital service came about as a healthcare provider for AIDS patients, stressed in his address that the Catholic health professional is not dealing with a disease, but with a peson who suffers from a fatal disease This successful joint venture of the Federation was co-sponsored with New York Medical College This personalistic approach was again dominant in the Conference of Coimbra, where the speakers discussed the statements circulated on matters of health originating from the Holy See.

National Organizations

Mention has been made of the fact that the Federation is represented in some forty countries Especially pleasing is that many recent applications from Latin American countries are being processed. A successful meeting in Bogota last year on health problems with CELAM was arranged for the first time with our new Vice-President, Hugo Obiglio, a continent where some years ago the Federation had few member countries

National associations hold local, regional, and national meetings, which are often ecumenical, and Catholic viewpoints on medical ethics are stated in medical journals and the national press So often, false ideas and statements about a Catholic medical viewpoint need to be corrected and explained at all levels. Membership of national associations can vary from as much as 12,000 in one country, to only 20 elsewhere. What is important is the activity in these organizations and not mere numbers Variation in the nature of the work of these national organizations is a distinct feature, especially their use by national hierarchies, which often appoint our members as medical advisors on various Church committees and commissions dealing with medico-moral and political matters.

Identifying emerging medico-ethical problems with possible resultant legislative implications is a vital part of the work of the national organizations and the Federation. A current example is the present experimentation on human embryos in many countries with the impending permissive legislation that will, or has in some countries, come about. *Donum Vitae* recently covered the ethical problems posed by assisted reproduction. Legislation on euthanasia may soon be enacted in some countries. It is important, therefore, to deal

with the ethical problems of modern genetic medicine, including the responsibility of counselling, the limits of genetic engineering, the prospects of germinal cell therapy, and the problems which will arise from the identification of the human genoma, when completed in a couple of years. This, again, was a joint venture with the Bioethical Division of Coimbra University

These international meetings have been co-sponsored by the Federation to deal with subjects of important and widespread impact on the ethics of medical practice; recognized experts are selected as speakers, since the Federation believes that in these matters Catholic testimony attains credibility only when backed by professional excellence

A third important service is represented by the publication of a bulletin as a source of news of what is going on in the complex world of Catholic thought and action in the area of health. The bulletin, entitled *Decisions*, now in its fourth issue, aims at promoting greater interaction and better communication between the member associations and to inform persons interested in this field.

The Federation is aware of the growing impact of biomedical ethics centers and groups on medical attitudes and even on legislation; fortunately, there are numerous and important Centers of Catholic inspiration scattered over the world.

The Federation's Bio-Medical Ethics Center, established in Bombay (whose director is a Past President of the Federation, Dr C J Vas), aims at close connections and fruitful exchange with other Catholic ethics centers and has an important activity in studying medico-moral problems which arise as a result of rapid advances in medical technology. It also has an information service to ensure that the Catholic laity and religious are alerted to these emerging issues and that advice is easily available from Catholic physicians. Much help comes, too, from other Christian organizations and persons who wish to see Christian moral imperatives emphasized.

National Publications

Many of the national organizations publish periodicals of a high academic medico-ethical standard, often containing papers from clinicians who come in contact with the daily lives of their patients and families. Such material can only come from practicing physicians who, therefore, have a unique experience to share. Those interested in obtaining such publications should contact the FIAMC Office, Palazzo S. Calisto, Città Del Vaticano 00120. *Decisions*, an international newsletter, is available at present free, through the kindness of a sponsor, and is sent to those involved in medical ethico-pastoral problems. To be put on the mailing list please apply to the FIAMC office.

How is the Federation organized?

Because of its international character and worldwide presence, the Federation has organizational difficulties. Fortunately, a permanent Secretariat in Rome is of great help in overcoming some of these difficulties, since the officers of the Federation meet twice a year in this venue. The Executive Committee is formed by the officers and by delegates elected by the different regions and holds its annual meeting also in Rome, the Ecclesiastical Assistant being present. The international character is well exemplified by the fact that the members of the Executive Committee come from thirteen countries, all contingents being represented.

Since the Federation is the international lay organization officially recognized by the Holy See to represent Catholic doctors worldwide, it is felt that it should increasingly correspond to this heavy responsibility by engaging in the world scene of health and medicine. To facilitate this task, the Federation is affiliated in the Conference of International Catholic Organizations (OCI) and is in close contact with the Secretariat of State, the Pontifical Council for the Laity, and the Pontifical Council for Pastoral Assistance to Health Care Workers. It plans to have an association with the World Health Organization and has at present two projects in mind to commence this link. Undoubtedly, much of its work would be impossible without the invaluable help and understanding received from these organizations, which is a reflection of the continued interest shown by the Church in the needs of the sick and suffering, as expressed in a few words by His Holiness John Paul II, when he granted a reception to the officers of the Federation and graciously remarked, "Our work has many things in common with your work." This is the best incentive for the Federation's trying to increase its action to respond better to the many challenges it faces.

THOMAS LINEHAN
President
GINO PAPOLA
Past President
WALTER OSSWALD
Secretary General of the Federation

The Christian Fraternity of the Sick and the Handicapped

The Fraternity is a movement for evangelization sustained by sick and handicapped people which has received from the Church the mission of revealing to sick and handicapped brothers and sisters the Good News of a God who is Love and Life.

In starting from solidarity and a fraternal Gospel spirit, it aspires and acts to foster the complete development of persons, their integration into and full participation in the life of the world and the Church

The Fraternity

It is a movement rooted in life

Like a grain of wheat ...

The Christian Fraternity of the Sick and the Handicapped began in Verdun, France, in 1945, through the initiative of Fr François, who was personally familiar with illness The Fraternity was sustained by the sick and handicapped themselves

The Founder died on February 3, 1986, at the age of eighty-nine, leaving the Movement well established

At present, the Fraternity is active in thirty countries around the world—in Europe, Africa, America, and Asia.

Why the Fraternity?

While not ceasing to develop its initial idea, the reason for which it was created, its motivation—*to activate the sick and the handicapped through the fraternal spirit of the Gospel*—the Fraternity goes on growing.

Peope are really moved when they see the sick and handicapped raise themselves up, take responsibility for their lives, and reject any kind of isolation or dependence for both themselves and others

To Believe in Life

Though current living conditions are not the same as in 1945, the need for complete development has not for this reason ceased. The Movement takes care to make itself present to others, with no discrimination based on race, creed, or environment. It aims to pay close attention to people's lives and all their surroundings and more than ever wishes to maintain its presence among and solidarity with those living in group facilities (nursing homes, residences, hospices), new cities, very congested urban neighborhoods, poor suburbs, rural towns, isolated, out-of-touch places, as well as those marked by poverty and sometimes marginalization, too, and those experiencing new conditions and aspirations: work, entertainment, marriage, political, union, and other types of membership commitments

All such states can be undergone on an individual basis, but also—and increasingly—on a collective one, for it is certain that "you can't get by alone."

To Participate in Life

The Movement invites its members to take part actively and progressively in building up the world and the Church in the place where they live.

We certainly receive, but we also have a lot to give. We are called to be jointly responsible together in the world and the Church

The Fraternity As a Church Movement

The Fraternity has always sought to be a movement closely tied to the Catholic Church.

The Assembly of French Cardinals and Archbishops officially recognized it in 1957 Since 1975 the Fraternity, as a movement for evangelizing the world of the sick, has been connected and has maintained regular contact with the Pontifical Council for the Laity and, more recently, the Pontifical Council for Pastoral Assistance to Health Care Workers in Rome.

Since 1974, to be able to accept members from other Christian denominations, the Movement adopted an ecumenical orientation (cf Statute, 1-3).

Within the Church, the People of God, along with other movements it carries out its mission of evangelizing the world of the sick and handicapped

A Lay Movement

The Fraternity is a movement of lay people We, the laity, are the first in charge of the Movement's organization, life, and mission

It is called to develop in teams at all levels (grass roots, diocesan, regional, national, continental). This responsibility is conferred upon us by our Baptism/Confirmation and our solidarity with the sick and handicapped.

Priests participate in the Fraternity's life of teamwork as chaplains—they are brothers, in the full sense of the generosity this word entails. Essentially, they authenticate the Christian meaning of what we live and express a reference to the Gospel. They celebrate with us. In this way, we have the conviction that we are sharing the responsibility of the People of God, united as priests and laity.

Deacons and men and women religious sometimes participate in this function of chaplaincy, along with Pastors from other Christian denominations who are the chaplains of ecumenical teams.

Bearer of a New Life

Through a friendship which seeks to be fraternal, open, and joyous, the Movement is the bearer of Good News: that concerning a God who is Life and Love, who wants the happiness of each man and all men.

We like to encounter the image of Jesus Christ welcoming the sick, the least ones, and saying, "*Get up and walk....*"

We wish to be able to discover this Good News increasingly, live it out, and be witnesses to it.

To Reveal It to All

This Good News must be revealed by us to all our sick and handicapped brothers and sisters in our own countries and on all continents. For this reason we are concerned about meeting them at every moment of their lives, in their needs and aspirations.

For their part, they can also discover that God close at hand, that God who causes them to rise—and, in turn, they can bear witness to Him. "On the day of Pentecost, the disciples were gathered together. They were afraid. The Spirit of God descended upon them and sent them throughout the world. We, too, feel sent to others to announce the Good News to them."

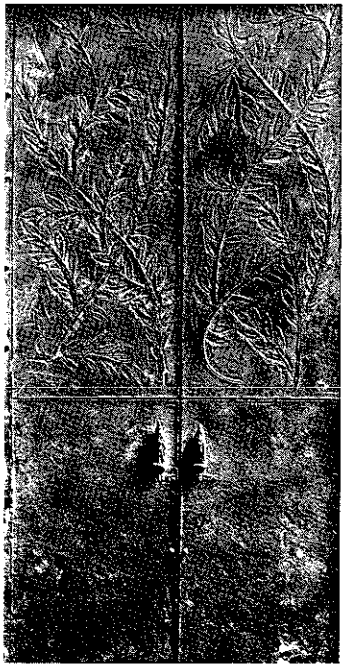
A Movement Open to Universality

The Fraternity rejects any kind of ghetto in the world or the Church. It seeks the complete integration of all sick and handicapped people.

We come together to be strong together and find ourselves in a positive state on the outside. This call to universality opens us not only to other fraternities beyond the borders of our country, but also to the Church and the world in their differences and wealth.

On a Mission with Others

The Fraternity is not alone—it wants to act with others. We are on a mission with other Christians, firstly with those who are concerned about the health care ministry, but also with the movements having the same project: that of making man grow and saying to him, "Get up and walk."



We want to be in contact with this Church in a missionary state today, a Church asking herself, with all men, about the meaning of life and man, and wanting to build a new world, a Church we must interpellate about the place granted to the sick and handicapped, a Church particularly seeking to adopt an attitude of listening and solidarity with other Christian Churches, other religions, and men of good will.

How is the Fraternity Built?

The Fraternity is built first of all *at the roots* by way of personal and community bonds among sick and handicapped people—visits, letters, meetings, friendship days.

It is an activity to which all can have access. All that is asked is for each to contribute the best of himself—friendship.

The Fraternity gives priority to *teamwork*, where each is invited to be responsible and strives to be so. In these teams all the members share the desire for greater fraternal presence in relation to all the sick and handicapped and together contemplate this whole life in the light of the Gospel.

The teams meet more or less regularly, whether the level be local, diocesan, regional, national, continental, or intercontinental.

For the Movement, this teamwork is essential, for together we become aware of our Mission, our being a Sign of the Church.

At certain points the local or diocesan teams propose a series of activities for all the sick and handicapped—friendship days, camps, shared experiences, peace marches in South America, demonstrations, and gestures of solidarity. Evidently, such activities do not constitute anything "in themselves." They are animated by a spirit of fraternity, with the constant desire to be present to meet people where they are and in what they are experiencing. The Fraternity in-

vites its members to participate vigorously in reflection and action relating, above all, to respect for human life, from conception until death, and to building a new society.

Adequate training is ensured at all levels, by way of meetings or sessions organized by the diocesan, regional, national, continental, and intercontinental teams

When it is a question of a country that is beginning, relations are overseen by the Continental Team or, if there is none, by the Intercontinental Team.

The means used for training are varied.

- Sessions on different points or topics
- A yearly campaign involving greater attention to a specific point in the lives of the sick and handicapped which serves to support this training and stimulates the life of all the teams with a view towards their Mission.
- "Integral" formation (more complete and organized) is proposed by certain countries.
- At Sameiro the different countries participating asked the intercontinental team to provide them with training material. At present the first materials (concerning formation and evangelization) are reaching the different countries.

In these texts the pedagogical perspective from which we start is always the same:

- an observation and a clear analysis of life or events (seeing);
- a reflection in the light of the Gospel and the Church's teachings to discern the demands of the Christian life (judging);
- a precise orientation towards concrete action (acting)

"I would be happy to leave this world," Fr. François would say, "with the certainty that I was leaving behind me a Fraternity, a Movement of Evangelization "

Mrs. CLAUDE TRONTIN
Director of the Fraternity
Fr. MANUEL MARTIN-NEBOT
Ecclesiastical Assistant

The Fraternity on Different Continents

Continents	*Affiliated Nations*	*Following Nations to be affiliated*	*Nations in contact*
Europe	Germany Austria Belgium France Portugal Switzerland Yugoslavia	Poland	Holland Hungary Czechoslovachia
North and South America	Argentina Bolivia Brazil Colombia Guatemala Mexico Peru Uruguay	Costa Rica Ecuador Honduras Salvador Venezuela Puerto Rico Cuba Martinique Quebec	Chile Nicaragua Panama
Africa	Madagascar East Zaire	Benin Burkina-Faso Burundi Cameroon West Zaire	Island of Mauritius Togo
Asia		Taiwan/Japan	

The Health Care Ministry in Peru

"Together we make life flourish"

This is the slogan heading and guiding the work of the Health Ministry Department of the Bishops' Conference of Peru

The Catholic Church has always carried out extensive work in support of the health of the country's poorest sectors, but since 1985 this effort has become broader, after the creation by the Holy Father of the Pontifical Commission for Pastoral Assistance to Health Care Workers. Through his Apostolic Letter *Dolentium Hominum* the Pope exhorted all the Catholic dioceses in the world to name special commissions whose object would be to delineate and orient pastoral care in health.

Accordingly, in July 1988, at the General Assembly of the Peruvian Bishops, the Bishops' Department for the Health Care Ministry was created, and the Most Rev. Augusto Beuzeville Ferro, then Auxiliary Bishop in Lima, was named to chair it.

Efforts were begun with a small group of pastoral workers in health, to which, at the invitation of Bishop Beuzeville, representatives of the country's different ecclesiastical jurisdictions were gradually added. All of them met in February 1990 to communicate the efforts made individually in their respective areas and thus get a general, reliable picture of the Catholic Church's work in this pastoral field.

Fourteen people appointed by their respective bishops attended that first meeting. It was a good number for a first encounter, but there were some notable absences which we hope will be corrected in the future. The object we pursued at that meeting was to establish the goals, lines of action, and work plans which ought to orient the health ministry nationally. This would have to be achieved with great respect for the action taken by the dioceses in that regard and attention to the various needs, charisms, and vocations within our Church. The agreements reached were as follows.

Objectives

1. To achieve the creation of a Commission to serve and defend life through Integral Pastoral Care in Health

2. To stimulate and promote Integral Pastoral Care in Health in support of the pastoral workers in different ecclesiastical territories.

3. To be the Church's spokesman in the face of the health problematic

— To provide support and encouragement to pastoral workers and health promoters.

— To be a Church interlocutor in relation to governmental and nongovernmental institutions in the health field

— To announce the values and principles fostering man's life and dignity from a Christian standpoint

— To denounce the injustices and abuses committed against people's health and integrity

Lines of Action

1. *Direct attention* to the sick with a social orientation (hospitals, clinics, dispensaries, asylums, first-aid stations, community visitors of the sick, etc.).

2. *Continuing education and qualification* of pastoral workers in health in terms of both pastoral aspects and professional services

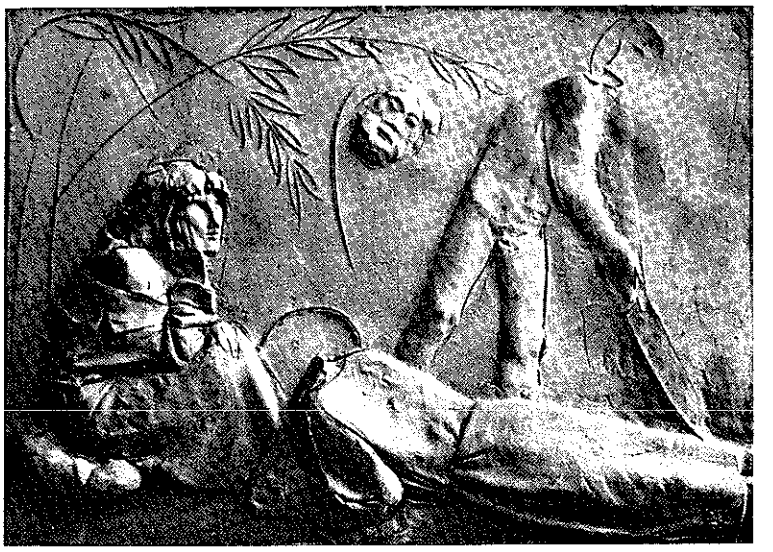
3. *Prevention and promotion* by means of

— organized patients' groups (alcoholics, TB victims, the handicapped, etc.);

— health committees (promoters, delegates);

— women's organizations (clubs, soup kitchens, etc.).

4. *Communication and dissemination* to achieve contacts and exchanges among pastoral workers throughout the country and serve to make known the lived experience in different places, which, no matter how humble it may be, involves interesting alternatives and can enrich and encourage us all.



Action Plan

1 To articulate and coordinate better work with other entities in the area.

2 To send each bishop, participating pastoral coordinators, and other pastoral workers as well a report on the meeting

3. To recommend that the ecclesiastical jurisdictions join in the health apostolate by naming a coordinator.

4. To promote area and regional events in terms of the health problematic and pastoral work

5 It was agreed to hold a second National Meeting, scheduled for September 9-12, 1990.

Some months later, at the meeting of the Bishops' Assembly in July 1990, Sr. Maria Van Der Linde was ratified in her post as Executive Secretary of the Department. Under the chairmanship of Bishop Augusto Beuzeville Ferro and the guidance of Sr. Maria Van Der Linde and the support team, the first Seminar on the Health Care Ministry took Place, September 9-12 of this year. At that event there was better attendance by the bishops' delegates, with twenty-five bishops represented from different ecclesiastical territories.

At this Seminar six regional divisions for coordinating this ministry were established, and a coordinator was named for each area.

This initial Seminar also motivated reflection by pastoral workers in health on the following aspects:

a) prompting an integral health approach in their daily work;

b) gaining deeper awareness of the place of the health apostolate in the Church's evangelizing mission;

c) structuring the efforts which are continually arising in terms of health work as defense of life.

All of these endeavors by the Health Ministry Department, as well as those by the country's different dioceses, seek to reflect the Holy Father's initiative and will and to succeed in attending to the immense deficiencies and needs existing in the health field in Peru. We hope that the motto "Together we make life flourish" will daily become a more concrete reality among the country's poor.

	Jurisdiction	*Coordinator*
Costa Norte	Piura Chiclayo Trujillo Chimbote Huacho	Sr. Janet Cashman
Jungle	San José de Amazonas Iquitos Yurimaguas Pucallpa	Sr. Blandini Massicote
Andean South	July Ayaviri Sicuani Cuzco	Sr. Teresa Kvale
Lima	South North West City	Fr. Emilio Sténico
Central Sierra	Huanuco Huancayo Chota Huaraz Chachapoyas Humachuco	Sr. Monserrat Bardolet
South Coast	Tacna	Fr. Juan de Dios Vicente

From My Bed I Could Appreciate and Value the Words and Gestures of Doctors and Nurses

The testimony of the Most Rev. Arnaldo Clemente Canale, Titular Bishop of Cabarsusi and Auxiliary of Buenos Aires, Argentina

His Death

News of Bishop Canale's death arrived unexpectedly, since few were aware that on Saturday, July 28, 1990, he had been admitted to St. Joseph's Sanatorium for care after the appearance of a pulmonary edema—in itself serious, but even more so in someone suffering from cancer, as he was.

His death occurred on Monday, July 30, at 6:45 p.m. Moments before he had recited a mystery of the rosary with the Most Rev. Luis Héctor Villalba, Auxiliary Bishop of Buenos Aires and Episcopal Vicar of Flores. His decease took place shortly thereafter. Bishop Canale maintained his lucidity until the end.

Spiritual Testament

Dear Father Lella:

I am sending you these lines not to apologize for not being able to celebrate the Mass on Relief Ministry Day, but to share with you some reflections.

At that Mass I would surely have emphasized the merit of actions performed by those who are close to the sick and how God values those acts of mercy.

It was not possible. The Lord, in the inscrutability of his ways, took me along another path: to observe the relief of the sick from the inside—an experience virtually unknown to me, who always believed myself to be so healthy.

In those days in bed I was able to appreciate the clear, sure words of the doctors and value what a nurse can mean who, after finishing her task, squeezes your arm or caresses your brow with a "Hang in there" unspoken by her voice and unheard by my ear, but truly felt by the heart. I learned to sense what it means to have a nun—or any good soul—at your side to smile at you while remaining ever ready to reach for a glass of water just in time to calm a coughing spell; in those days I learned what support and security is provided by the arm of the Sister, who, sitting at the head of the bed, firmly supports your head when the organism violently struggles in rejecting medication.

I felt many things in those days—they are not great or important, perhaps less "arduous" and more sensitive, but that was all I needed: understanding, love, and security.

The prayer of those outside. How it moves one's heart to know that there are many others praying for one, concerned about one's problem. What can be said in the face of the nurse who went to St. Nicholas' and brought me back a rosary of Our Lady and told me that "on the way back we were praying for you."

That is my case, a case multiplied by thousands.

Thank you, then, all who are secretly opening this way of mercy for the sick, so that we may all comply with the Will of the Lord.

Father Lella, a big *abrazo* and my pastoral blessing.

Buenos Aires, November 24, 1989.

✠ CLEMENTE CANALE

1990-1993 Action Plan of Spain's Health Ministry Department

Introduction

The National Health Ministry Team, at its Twenty-Ninth Meeting, in assimilating contributions made by the Commissions and the Diocesan and Interdiocesan Secretariats, established the major objectives for the the 1990-1993 Action Plan of the Health Ministry Department.

Evaluation of the preceding three-year period revealed that the most significant achievements were the consolidation of Patients' Day, the initiation of the different Commissions of our Team, and, in some dioceses, greater sensitivity in Christian communities to the most neglected patients, an increase in the demand for training and in the supply of means for training in dioceses, an augmented PROSAC presence, etc.

Analysis of the current situation in the health world, a reflection of the society in which we live, poses two *major challenges*: 1) to promote a new culture of health which, starting from the Gospel, will give new meaning to life, health, illness, suffering, death, and care; 2) to promote effective solidarity with the poor, who, in the health field, have specific names: the sick and, among them, the neediest and most neglected.

On both fronts, which profoundly coincide, efforts must be intensified and new action be carried out which will give greater depth and concreteness to the Church's option for the poor, her special sensitivity to grasping what is urgent at a certain moment and, at the same time, her contribution to the humanization of health, suffering, life, and death. At the very heart of ethical problems there lies the urgent need for a new culture, more solidary and more human.

For the present three-year period, which is taking us closer and closer to the third millennium, our general objective will be that of the Spanish Bishops' Conference: to spur new evangelization in the world of health. And the specific objectives will continue basically to be those of the preceding period. We have added two: Objective 4: "To renew the evangelizing action of parishes in the health field"; Objective 8: "To spur and develop our relations with ecclesiastical and civil organisms on a national and international level." To achieve these goals, the plan proposes definite action.

The plan drafted by the National Health Ministry Team seeks to provide a framework for reference which will chart the course for pastoral care in health, permit the communion of all involved and the unity of their apostolate in this area, and help us to situate the different activities programed in the varying spheres.

General Objective

To Spur a New Evangelization in the World of Health.

Specific Objectives

Objective 1. To shed light on the realities, problems, and situations posed in the world of health and their pastoral implications.

Actions

1. To spur and develop theological-pastoral reflection on health, suffering, and death, involving therein pastoral workers, Scripture scholars, theologians, catechists, and pastoral experts.

2. To promote interdisciplinary reflection on the following ethical problems with a view towards clarifying them:

— ethical problems in psychiatry;

— ethics of the quality of life;

— quality of health care and the responsibility of the health professional.

3. To draft a document on "The Church and Health for All in the Year 2000."

4. To pay close attention to situations of conflict which may arise in the world of health in order to make an enlightening statement concerning them.

Objective 2. To intensify the solidarity of the Church and society with the most neglected patients, especially those who are terminal or psychiatric.

Actions

1. To implement the measures contained in the Spanish Bishops' Action Plan on euthanasia and assistance for a good death which refer to achieving integral care for terminal patients.

2. To study the serious problems psychiatric patients and their families face today in Spain and promote the coordination of Church members and institutions and their collaboration with government insofar as possible to provide them with proper care.

Objective 3. To consolidate Church communion among workers and organisms in the health ministry.

Actions

1. To develop shared responsibility among all pastoral workers in health in both drafting and implementing plans.

2. To foster the coordination of guidelines, objectives, and activities among the Diocesan Health Ministry Delegations while respecting the pace and circumstances of each.

3. To spur implementation of a Mutual Aid Plan among the Health Ministry Delegations as a way of living out Church communion.

4. To open up channels for mutual knowledge and collaboration with the Churches of Central and South America.

Objective 4. To spur renewal of the evangelizing action of parishes in the health field.

Actions

1. To create awareness in parishes of their healing mission and develop their resources to promote health.

2 To revitalize parishes' real commitment in integral care of the most neglected patients, particularly those who are terminal, elderly, or psychiatric.

3. To promote parishes' knowledge of the major health problems and their participation in finding solutions

4. To continue to spur the creation and activity of health ministry groups in parishes

Objective 5. To spur the solid functioning of Catholic Religious Assistance Services at hospitals.

Actions

1 To support, accompany, and stimulate chaplains and suitable persons in the realization of their mission by organizing meetings, arranging for visits and exchanges among them, and providing instruments and means, among other things.

2 To spur communion and collaboration among chaplains and as regards their relations with men and women religious and health personnel at facilities and in parishes

3. To clarify the figure of the 'suitable person,' his field of action, training, obligations, and rights.

4 To study the middle-term need for trained personnel, religious and/or lay, to provide religious assistance at both hospitals coming under the Religious Assistance Agreements and facilities where this service has not yet been regulated.

Objective 6. To continue to promote a laity committed to the world of health

Actions

1 To organize the PROSAC Meetings each year as a place of encounter, reflection, and commitment

2. To promote a yearly "seminar" on a topic in bioethics as a means to facilitate PROSAC ethical formation and capacity to speak out in the Church and health circles.

3 To spur the creation and functioning of the PROSAC Commission in all dioceses.

4 To expand the PROSAC National Commission with a PROSAC representative from every SIPS

Objective 7. To spur specific, ongoing training of pastoral workers in health.

Actions

1 To design models for programs to train pastoral workers in health at basic and intermediate levels.

2. To offer one or two courses each year for the continuing education of these pastoral workers.

3. To collaborate in preparing programs and documentation for bioethics seminars to be organized

4. To advise and collaborate with training activities in the various sectors: Schools for Pastoral Care in Health, training courses for seminarians, visitors of the sick, volunteers, etc

5 To organize a documentation, information, and publication service with the means and material to train pastoral workers in the health field

6. To work for the inclusion of bioethics in curricula for future health professionals

Objective 8. To spur and develop our relations with ecclesiastical and civil organisms both nationally and internationally.

The National Level

— Commissions and Bishops' Secretariats connected with pastoral care in health.
— Faculties of theology, pastoral and bioethics institutes, seminaries
— Catholic Charities
— Volunteers.
— Ministry of Health.
— Others.

The International Level

— The Pontifical Council for Pastoral Assistance to Health Care Workers
— International Federations: CICIAMS, Catholic Medical Associations, Caritas International.
— Others

October 1990

Treatment of the HIV Infection by the Clinical Institute for Infectious Diseases at the Catholic University of the Sacred Heart in Rome

1. Modes of Care

At our Clinic care is provided for patients with the HIV infection on three levels: the *out-patients' department*, the *day hospital*, and the *hospital wards*.

The **Out-Patients' Department**, with two rooms, is open every working day for about six hours. Continuous follow-up for patients is administered therein. Among other things, it is in this department that patients being treated with zidovudine are enlisted and followed up.

The **Day Hospital**, located near the out-patients' department and separated from the wards, is endowed with four beds, with the possibility of admitting six patients a day. It is used a) in cases where it is necessary to concentrate a series of procedures needed for rapid diagnosis (endoscopies, biopsies, consultation of specialists, TC and other instrumental examinations, in addition to routine testing) within the span of a single day or slightly longer; b) for those patients who need treatment in the presence of medical and nursing personnel (hemotransfusions, antineoplastic chemotherapy cycles, prophylactic therapy with the intravenous or aerosol infusion of pharmaceuticals which are unregistered or experimental, such as ganciclovir or pentamidine).

Finally, the two **Hospital Wards** offer a total of fifty-five beds. The use of the wards tends increasingly to be limited to patients with full-blown AIDS in an acute phase, in serious condition, or to those at different stages of the infection, like ARC, who present an acute symptomatology linked to the infection itself or to special situations of infectiousness which in any case involve hospitalization in an infectious disease ward.

2. Our Activity

From January 1, 1985 to December 15, 1989 730 patients with the HIV infection were observed by our Clinic. The distribution of these subjects according to the classification proposed by the CDC for HIV infection shows that 24% of the patients had already reached the full-blown stage of the infection; 34% were at an intermediate stage (PGL or ARC); and 43% were still asymptomatic. This distribution refers to the condition in which the patient was found during his last visit to the out-patients' department or last hospitalization.

Of the 730 patients followed up, 272 were hospitalized at least once in the course of the period considered. These 272 subjects had a total of 541 hospitalizations during the 1985-1989 period, for an average of 1.99 hospitalizations per patient and a total of 19,332 days of hospital stay. The average stay per hospitalization was 36.14 days, whereas the average total number of days spent hospitalized was 71.07 per patient. The total of days in which people were followed up at the out-patients' department, at the day hospital, or in the wards was 111,844, for an average of 414.24 days per patient. The result is that the percentage of time spent in the hospital from the date of hospitalization until death—or until 12/15/89 in the case of those still alive—was 17.3%.

In addition, at our Institute intense research activity is conducted on the HIV infection involving epidemiology, immunology, pathogenesis, clinical aspects, and therapy.

December 1989.

LUIGI ORTONA, M.D.

Statute of the Tuscan Regional Council (Italy) for Pastoral Care in the Field of Health

I

Nature and Ends
Of the Regional Council

Art. 1
Nature

The Regional Council for Pastoral Care in the Field of Health is an organ instituted by the Tuscan Bishops' Conference on a stable basis, for the purpose of study and promotion in the health sector.

Art. 2
Ends

The Regional Council for Pastoral Care in the Field of Health pursues the following goals:

— to study the problems connected with Pastoral Care in Health at every level, from a theological, pastoral, and juridical standpoint, for the purposes of evangelization, catechesis, pastoral activity, cultural orientation, and drafting legislation, on the one hand, and the participation of Christians in all phases of the civil administration of health care, on the other;

— to foster the formation of a Christian conscience and vision as regards the problems of life and death, health and suffering, in the Church community and civil society;

— to coordinate Church activity involving Christian presence in the world of suffering so that Christian values will be taken up everywhere, along with respect for the dignity of the human person and the inalienable rights of the sick;

— to collaborate, in accordance with its own aims, in the formation of those providing religious assistance and the personnel engaged in any kind of work—including volunteer work—at public medical facilities, at private clinics, and, in any case, within the territory involved, while leaving unchanged the institutional duties and ends of the professional associations, seminaries, and religious institutes;

— to promote initiatives for more effective, rational distribution of Church resources in relation to facilities, organizational channels, and personnel, at the request of the Ecclesiastical Authority having jurisdiction;

— to facilitate the integration of pastoral care in health into the sensibility, life, and pastoral plans of the particular, local Churches;

— to contribute to knowledge, collaboration, and unified action involving all the Church institutions and associations engaged in the sec-

tor, including those which are voluntary, with respect for the aims and autonomy proper to each;

— to present timely proposals to the Tuscan Bishops' Conference by offering the specific competence and experience of individuals and Church groups working in the sector and cooperating with other Conference organisms in areas for which there is joint responsibility

The Council, in carrying out the plan of activity approved by the competent statutary bodies of the Tuscan Bishops' Conference, also performs operative functions

II

Structure

Art. 3

Organization

The Councils instituted on a local level by diocesan Bishops are connected with the Regional Council.

The Regional Council, following the orientations of the National Council, promotes and stimulates their action while respecting their autonomy in regulation and functioning

Art 4

Organs

The organs of the Regional Council are the Assembly, the President, and the Board

Art. 5

The Assembly

The Assembly is made up of:

— the Bishop delegated by the Tuscan Bishops' Conference, who acts as President;

— the Regional Delegate;

— the Deputy Regional Delegate;

— the Regional Secretary;

— the Regional Delegate of Catholic Charities;

— the Diocesan Delegates named by their respective Bishops;

— a representative of each Institute of Consecrated Life especially engaged in health care and of the associations and bodies authorized to form part of the Council in accordance with Art. 7—the latter is designated by the respective competent organs;

— a representative of the Regional Council for the Church's Charitable and Relief Activities.

Art 6

The President

The Bishop President calls and chairs the meetings of the Assembly and the Board and directs the Council's activity

In the event that he is unable to do so or is absent, his functions are performed by the Regional Delegate or his Deputy, in agreement with the Bishop President and for the purposes of their specific jurisdiction.

The Bishop President, in carrying out his functions as director of the Council's activity, avails himself of the collaboration of the Regional Delegate, the Deputy Delegate, and a Secretary named by him

Art 7

The Board

The Board is made up of:

— the President of the Council;

— the Regional Delegate;

— the Deputy Regional Delegate;

— the Regional Secretary;

— the Regional Delegate for Catholic Charities or his representative;

— four members elected by the Assembly.

The Board has the following functions:

— to decide about accepting new members to the Council, as discussed in Art. 5

— to program the activity of the Assembly and execute its decisions;

— to make urgent decisions;

— to be responsible for public relations and every action made necessary by the life and development of the Council, particularly relations with the National Council.

Art 8

Experts

The Council's organs consult some experts, who may be invited to meetings, without the right to vote

Art. 9

Terms of Office

The members of the Council hold their posts for five-year terms, which may be renewed indefinitely

III

Activity

Art 10

Meetings

The Regional Council is convened for its Ordinary Assembly by the Bishop President or by the Regional Delegate, by order of the President, twice a year

It may be convened for an Extraordinary Assembly whenever this is deemed necessary

The Board meetings are called by the Bishop President or by the Regional Delegate, acting in his stead, whenever this is deemed appropriate.

The minutes of the Assembly and Board meetings are drawn up by the Secretary and sent to the Secretary of the Tuscan Bishops' Conference and to all the members of the Council

Art. 11

Special Commissions

For the study of problems or the implementation of activities or relations requiring particular competence, special commissions may be constituted at all levels

The members of such commissions, who must belong to the Council, are named by the President after he has heard the Board's opinion

Art 12

Relations with Ecclesiastical Authority

The following are submitted for the examination and approval of competent organs of the Tuscan Bishops' Conference:

— the conclusions and proposals drawn up by the Council or the Board;

— prospective documents or statements intended for publication;

— the plan for each year's activity, to be presented by September 30 of the preceding year.

The Bishop President informs the Tuscan Bishops' Conference on the activity of the Council whenever he is asked to or deems it appropriate.

Art 13

Relations with the Secretariat of the Tuscan Bishops' Conference

The Secretary of the Tuscan Bishops' Conference may take part in the meetings of the Council's organs, with the agreement of the Bishop President of the Council

The Conference Secretariat provides Council members with information, data, and copies of documents which are of interest to them

Art. 14

Collaboration of the Offices of the Conference Secretariat

To prepare meetings, draft documents, and satisfy all other needs, the Council avails itself of the collaboration of the Conference Secretariat

Art 15

Economic Means

The Council provides for the financing of its activity with its own means, and the Tuscan Bishops' Conference may also make contributions.

IV

Final Provisions

Art. 16

As regards all that is not provided for by the above norms, reference should be made to the Statute, to the Tuscan Bishops' Conference Regulation, and to the provisions of Canon Law

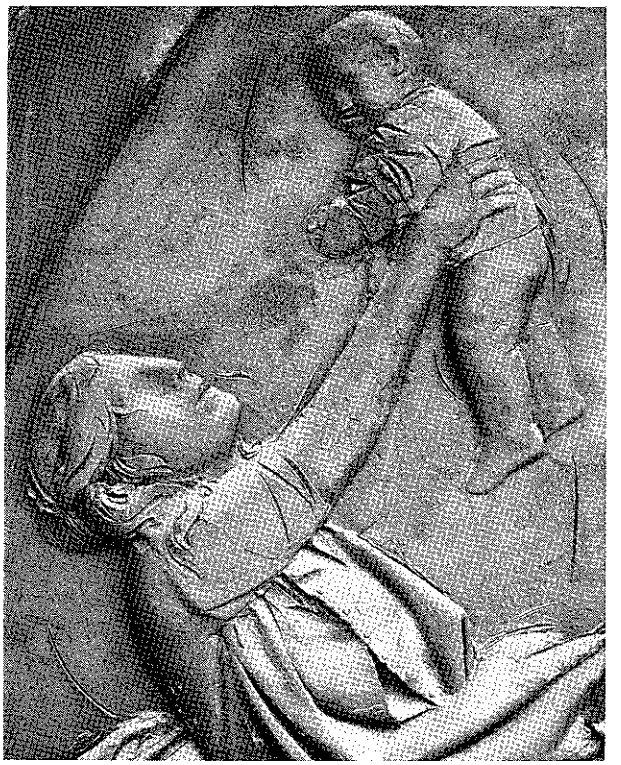
Approval

This Statute was approved by the Tuscan Bishops' Conference at its meeting in Pescia, April 3-4, 1989

Silvano Cardinal Piovanelli
President
Most Rev Luciano Giovannetti
Secretary

Diocesan Bulletin of Florence
(March-April 1989)

Pontifical Council Activity



Talks

Chronicles of Trips

The Church Is Qualified by the Concern and Assistance She Offers to Those Who Suffer

Fiorenzo Cardinal Angelini's words at the New York Medical College in Valhalla, New York, on receiving an Honorary Doctorate from this institution on January 31, 1991

It is not easy to express in a few words my deep sentiments of satisfaction and gratitude, and the honor I experience at this time. The fact that it is a prestigious institution properly known and referred to as a "Medical University in the Catholic Tradition" which is sponsoring this act of recognition certainly places today's ceremony in an ideal context.

I convey my most sincere thanks to His Eminence, Cardinal John O'Connor, who has wished to propose me for such a lofty distinction; to the entire Board of Trustees of the New York Medical College; and, in a very special way, to Monsignor James P. Cassidy, a friend for whom I have the greatest esteem, with gratitude for the fraternal collaboration he has always provided for my pastoral activity.

The motivations accompanying the granting of this Doctorate, I feel, go far beyond my own person. On accepting it, then, I sincerely seek to interpret it as signifying a recognition of the Church's growing involvement in the field of health policy and care. An involvement which, through the providential initiative of John Paul II, has been further implemented by the institution and increasingly broad activity of the Pontifical Council for Pastoral Assistance to Health Care Workers, represented here by its Secretary, Fr. José Luis Redrado, and myself.

I regard it as a privileged gift of God, through the mediation of the Most Blessed Virgin, to have been able to devote my life as a priest and a Bishop to the pastoral care of the sick.

This experience has brought to maturity in me the deep conviction that, especially in our time, this aspect of Christian witness is precisely the priority factor for encounters and solidarity among all men, who, in defending life and promoting health, recognize themselves to be brothers and sisters.

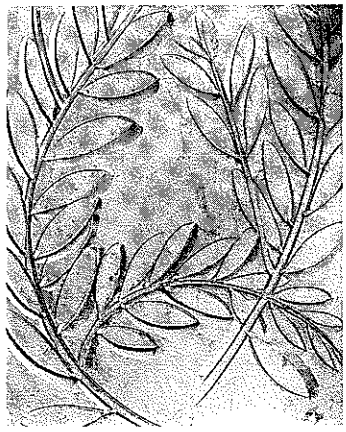
There is no Catholic medicine, but there must be medical research and practice which, inspired and sustained by our faith, are capable of becoming, in a prophetic, anticipatory way, the promoters of genuine, constructive service to life; a service which is all the more urgent the more threats to and aggressions against life become serious.

I invite all of you—professors and students, researchers and scholars working for an ever more humane and humanizing medicine at this distinguished Medical College—to believe in your vocation and mission and bear exemplary and forceful witness to them always and everywhere.

May I be allowed, finally, to express the special feeling of satisfaction I experience on receiving this distinction in the United States of America, a country to which I have always been linked by family ties as well, for my parents were married here.

I accept and regard this degree as further proof of your communion in aims and efforts to make the pastoral care of the sick around the world a prophetic sign of the Church's healing action.

Thank you.



The Role of Information in the Healthcare System

Fiorenzo Cardinal Angelini's contribution to the Round Table on "Information and Health" organized by the ANSA Agency and held in Rome on February 19, 1991

In the phrase "the role of information in the healthcare system" there is implicitly contained a basic truth about which we cannot fail to agree. Information certainly plays a significant role in the healthcare system. The difficulties arise when one attempts to establish what this role is, what information is being referred to, and what the precise domain and conception of "healthcare system" are.

The importance of information in a healthcare system which is socialized to a maximum degree is obvious. This is true to the point that radio, television, newspapers, and magazines increasingly maintain today fixed slots devoted to health information, especially in the area of prevention. However, anyone somewhat familiar with places of hospitalization and care has first-hand experience of a paradox. In spite of this avalanche of information, massive ignorance is observed. Doctors and health workers encounter each day generalized disinformation which makes the doctor-patient relationship (or that existing in general between health workers and those receiving care) even more difficult than it already is by nature.

Personally, I am convinced that the reason for this sharp incongruence is that there is a great deal of information, but very little health education.

Now then, health information is to health education as scattered notions are to real culture. There can surely be no culture without a rich stock of notions, but these alone do not suffice to create culture, which is synthesis—that is, the capacity to gather together the multiple tesseras of notions into the ordered mosaic of an organic vision of the whole.

In the healthcare system, information must be such as to educate in the problems of health policy and care. By health care I mean everything concerning prevention, diagnosis, therapy, and rehabilitation with a view towards the best psychophysical balance of the person; by health policy I mean all that regards strategy, legislation, and planning in the health field in each country.

Of course, health information and education are not separable; information must aim at education. This assumes acceptance of certain principles without which it is impossible to provide correct information and, therefore, proper education.

I must state at once that I am not thinking of principles which, in order to be accepted, demand Christian faith, for experience has also led me to some convictions which I feel can be shared by all.

If everyone is concerned about life as about nothing else and, consequently, about health, there is no field or world, if you will, which unites human beings as much as that of safeguarding and recovering health. This is, I believe, the most ecumenical and, therefore, unifying truth among men, independently of differences in race, age, social condition, ideology, cultural background, and even religious faith.

Here is the first presupposition, then, which I feel should inspire information in the healthcare system—i.e., information intended for health education: the culture of life, of all life and the life of each man, from its conception to its natural close. Not the life of some, while prescinding from others or even at the cost of the lives of others. Not just physical life, while overlooking man's psychic and spiritual component. A culture of life, not physical culture. Respect for the dignity of the integral human person, not the exaltation of the strong and marginalization of the weak. A culture of life, not just when life is entrusted to the extreme care of hospitalization, but in every environment—in the family, in the school, at the workplace, in assistance to the elderly, in making the most of opportunities for senior citizens and the disabled. A culture of life that will be global, not selective or discretionary, for if love of life unites all human beings, fear of illness and death also joins them.

There is often talk of an ethics of information, though people mostly limit themselves to identifying it with specific professional deontology. We must honestly and realistically acknowledge that information is always closely related to ethics, i.e., to certain basic human values, and if it overlooks or contradicts these, it becomes disinformation. Please allow me an only apparently trivial example. The information which is visualized as prevalent, if related to

health information and education, is, in fact, often deviant The tendency to exalt only youthfulness and good looks predominates, while the problems linked to childhood, advanced age, the sick, and the weak are presented in such a way as to provoke at best compassion and understanding—not, indeed, to arouse feelings of justice and equity

The socialization of medicine reflects the fundamental human right to physical, psychic, and spiritual health A right postulating a response of justice, which information is called to stimulate and promote.

Television, radio, and the major periodicals give prominence to every advance in medicine and transplant surgery, but little or no space to the problem of the donation of organs, without the availability of which the socialization of transplants, including those now devoid of risk, remains a mirage

As for the most dangerous current social illnesses, such as alcoholism, drug addiction, and AIDS, information services prefer to offer sensational data, and the political mentality itself observes the advanced stages of these epidemics with little concern about preventive information which, if translated into education, would no doubt play its role more adequately

In what falls within my province as the head of a Pontifical Office involved with the problems of pastoral care in the health field, I can state that at the Catholic institutions which in very large numbers all over the world provide medical care, attention to the aforementioned problems in bioethics confirms a growing concern about regarding health policy and care in global terms. In this sense, we are working for humanity in medicine and prevention which, starting from the recovery of the values linked to a culture of life, will awaken a new and broader social sensitivity to health problems.

John Paul II stated in a recent document that the Church's attention to the suffering and the most neglected is a basic aspect of her mission today, precisely because it sets up a culture of life against a "culture of death."

In summary, the role of information in the healthcare system first of all involves educating each and every person to regard the problems of policy and care as a moment qualifying a civilization which will be at the service of life Such a role must be given space particularly in the school and in the mass media.This will, however, be possible only if major cultural institutions, like universities and especially medical schools and sociology and education departments, include health information aiming at health education in their curricula

I feel that the demand emerging from society in this field, whether explicitly or implicitly, is very high It is a demand for civilization, since civil progress should be measured, above all, by the capacity to respond to the demand for life.

Health and Peace for Development and Democracy

Address by Fiorenzo Cardinal Angelini President of the Pontifical Council for Pastoral Assistance to Health Care Workers, at the Third Madrid Conference May 1-3 1991

Esteemed President of the Conference,

Distinguished Ministers of Health,

I am indeed very grateful for your invitation to participate in this third International Conference. The two previous Conferences organized by the Pan American Health Organization in collaboration with the World Health Organization and with the active and solicitous participation of the Spanish Government, also offered me the occasion to participate, and with great interest The work which you have begun —as complex as it is difficult— has certainly yielded abundant fruit, and in such a short period of time

I believe that, during this same timespan, the Pontifical Council, over which I have the honor to preside, has not only given evidence of the attention and the sensitivity of the Holy See regarding those problems dealt with at high-level government encounters such as this one, but of the Church's intense commitment as well, both concrete and effective, in order to contribute to the solution of the most pressing problems in today's world.

The Catholic Church is widely present in the Central American countries (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama), and the coming fifth centennial of the Discovery of the New World is indeed the cause of

meaningful celebration, not so much as a festivity but rather with a view towards the renewal of her mission of service

The Church is an attentive observer of the programs of the World Health Organization and of all the organizations, such as the Pan American Health Organization, which collaborate with WHO in the united effort to achieve the goal of Health for All by the Year 2000

The second phase of the project on the priority of health problems in the Central American region focuses on the conviction that the promotion of ideal health conditions for all is an indispensable supposition for the consolidation of peace, the promotion of development and the strengthening of democracy.

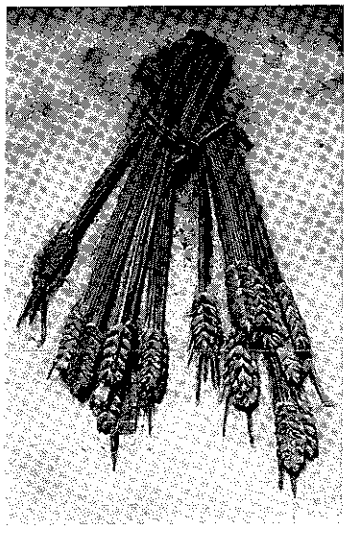
An enlightening passage from John Paul II's Encyclical on the Church's interest in the social world affirms:

"True development, in keeping with the *specific* needs of the human being—man or woman, child, adult, or old person—implies, especially for those who actively share in this process and are responsible for it, a lively *awareness* of the *value* of the rights of all and of each person It likewise implies a lively awareness of the need to respect the right of every individual to the full use of the benefits offered by science and technology" (*Sollicitudo Rei Socialis*, 33)

The right to life and to a quality of life worthy of the human person is a fundamental right of each and every man The basis of this life quality is to be found in the protection and recuperation of health, understood as physical, psychic, and spiritual well-being, and, therefore, as peace, the fruit of justice, which, in turn, is the condition for freedom's progress, and hence a democratic order The observation of the deficiencies in the health field—both in practice and promotion—provides sufficient data to understand those less fortunate countries' needs for the securing of peace in their societies and with this peace, progress and democracy

As John Paul II has courageously demonstrated in his magisterium and ministry, there is no alternative to peace in our times Without peace the progressive interdependence of the nations causes outright divisions instead of serving as a reason and factor for progress The negation of peace is comprised not only by the set of wars provoked for a wide variety of reasons The negation of peace and of its premises is, above all, the social injustice which derives from the structures of sin Paul VI, in 1967, spoke of peace as the "new name of development" (*Populorum Progressio*, 87) Peace in the world, however, is unthinkable if the responsible parties do not achieve the restoration of a social and international order which ensures for all the acquisition and exercise of fundamental human rights (cf *Sollicitudo Rei Socialis*, 39)

As was recalled at the First Madrid Conference, health does not signify only a primary fundamental human right, but likewise constitutes the grounds upon which it is possible to work together, beginning from widely differing ideological, political, and even religious tendencies The topics and problems concerning health, by the very nature of reality, actually possess one principal theme for all those involved Once these problems are recognized and solved, it will be possible to walk together towards peace, contribute definitively to the development of peoples, create the conditions for living in freedom and democracy.



The Pontifical Council for Pastoral Assistance to Health Care Workers moves ahead in this sense, according to its competence, in a triple direction which I believe can be particularly helpful in promoting cooperation

The first takes shape in the information and coordination of the diversified, many-sided presence of Catholic health care institutions in the developing countries The Pontifical Council proposes the support of health assistance which does not limit itself to the care of the sick, but rather actively works in the field of preventive and educational health care Both of these require activity in each locality which reaches the roots of social evils, detecting in them their moral and ethical component, without which science, as well as technology, runs the risk of failure A serious and efficient health care policy must refer to some basic, undeniable principles, among which there stand first and foremost respect for human life and the promotion of the quality of life for all Commitment to health can never be discriminatory As a consequence, all programing must rigorously respect this universal criterion

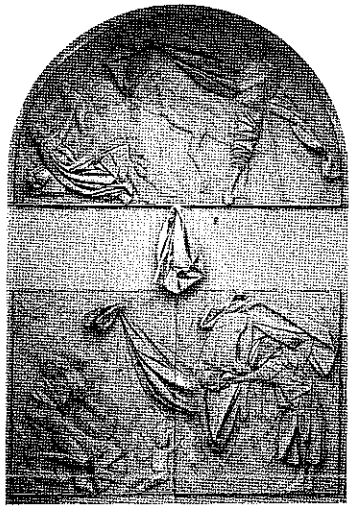
Secondly, in accordance with her tradition and experience as a pioneer in this field, the Church recognizes in her service to the suffering action which is not reducible to the use of materials or even to the professionalness offered by health care staff This is an activity, or better still, a *vocation* and mission which must grow in the awareness of equality of all men, each one of whom

is a child of God. This certainty must be the nucleus of prevention programs, of educational programs, of action to be taken in the world of suffering and health, and, above all, in training programs for health care personnel, particularly in nations with a solid Christian tradition. Health policy which is endowed with considerable economic dimensions must proceed according to the clear vision of the nature and dignity of the human person. This entails a hierarchy of options and a certain priority in the elaboration of health policy programs. Accordingly, the already generalized abortion legislation, the underestimation of care to the handicapped, and the postponement of a decisive program to obliterate the endemic diseases which attack the weakest social groups all represent serious obstacles to the achievement of the goal of health for all.

One of the merits of the initiatives taken on by this periodical International Conference is the administration of careful studies of the health care problems of the nations represented and the attempt to unite the results to the programs of the national governments. This spirit of dealing with concrete reality has made possible the achievement of satisfactory development in some cases. The development of a specific regional area is either global or nonexistent. It is evident that tangible, irreversible progress in the health conditions of one region is not at all possible if, at the same time, action is not taken to solve other problems of a political, economic, and social character.

The third line of action to which the Pontifical Council for Pastoral Assistance to Health Care Workers aspires in its activity is found in the fact that the Church seeks to be present and to collaborate closely with all those who, on any level, consider the protection ad promotion of health as a central aspect of the political and social action of nations. There is no doubt that the Church can do extensive work in the field of increasing awareness of these problems, and her numerous health care facilities located throughout the world can and wish to be in the vanguard of those programs directed towards the resolution of the most serious problems which afflict the weakest populations. Once again, in this solemn convocation, I am pleased to renew this commitment of the Church and to confirm her complete willingness to support decisions and initiatives which will be treated and activated by this Conference to secure the realization of health care programs which, while consolidating peace, will certainly be the premise of progress in freedom.

The Declaration signed last year in Belize can represent a historic moment for Central American Countries, above all if events demonstrate a progressive involvement of international organisms to achieve the goals proposed by this Conference.



Medicine: Art and Science, Vocation and Profession

Address by Cardinal Angelini at the European Symposium organized by the Catholic Medical Association of Italy and the Smith-Kline Foundation Rome, May 3-5 1991

I was to have opened this Symposium by dealing with medicine as an art and a science, a vocation and a profession. I find myself, instead, concluding your sessions, while, however, having to deal with the same topic.

The papers presented at this Symposium and the twofold Round Table have practically illustrated all the aspects which medicine as an art and a science, as a vocation and a profession, asks of young doctors in a Europe without borders. Obviously, when Europe is really without borders, new problems will also be posed, especially if we consider that the presence of freely circulating young Italian doctors has been minimal.

This important Symposium has carefully examined the contours of training in the different European countries, the structure of medical studies in Italy, the motivations of students entering Faculties of Medicine, the occupational choices of young graduates, and the new possibilities opened up by the process of European reunification—all of these subjects viewed under their most significant aspects and with the participation of experts from Italy and many other European countries.

Without a doubt, there is always something to be added on each of these facets, and the experience of the Pontifical Council for Pastoral Assistance to Health Care Workers in recent years is significant, precisely be-

cause we seek to act on a world scene, drawing inspiration from the solidarity which John Paul II has indicated as the new name for Christian charity (John Paul II, Encyclical Letter *Sollicitudo Rei Socialis,* 40). But this is not the point I would like to dwell upon, for, in addition, on medicine as an art and a science, as a vocation and a profession, there are very authoritative documents, and volumes and volumes have been written since the Hippocratic Oath, with provident insight, practically summarized and defended this fourfold aspect of medicine, which is an art, but also properly a science, if considered in its intrinsic value; but it is at the same time a vocation and a profession, if regarded in its exercise. A vocation and, I would say, a *mission*, inasmuch as it is a response to the most universal, deeply-felt, and pressing demands rising from the heart of every human being.

The sphere of medicine, its boundary, is traced out by an exact and exhaustive definition of the concept of health care, which embraces all that concerns prevention, diagnosis, therapy, and rehabilitation for the best psychophysical and spiritual balance of the person. Medicine, as an art and a science, as a vocation and a profession, moves on the stage of a culture of health. This culture demands a spur towards development and progress; but, as John Paul II writes, "True development, according to the exigencies proper to the human being... implies, especially on the part of those actively intervening in this process and responsible for it, a lively awareness of the value of the rights of each and all, in addition to the need to respect everyone's right to the full use of the benefits offered by science and technology" (cf. *The Humanization of Medicine, Proceedings of the Second International Conference of the Pontifical Council for Pastoral Assistance to Health Care Workers,* in *Dolentium Hominum,* no. 7, 1988, p. 6). A culture of health amounts to a culture of life—of the life of all and of the whole life of each human being, from conception to its natural close. The ethical dimension in medicine proceeds on a line parallel to the scientific and professional dimension. Hence the urgent need for young doctors to be prepared to place themselves at the service of health by moving in the area of a culture of life. Service to health, in turn, particularly in our time, covers an ever-vaster set of problems which are both individual and social and require choices linked to precise cultural orientations with immediate reference to principles of general and specific ethics.

If this is the overall picture, I feel it is basic—in regard to the training of young doctors, their specialization, and their integration into the most varied activities—for them to love medicine and, with medicine, those to whom it is addressed. Every profession is an art and a science and, if freely embraced and exercised with the maximum commitment, a vocation. But it is such if it is loved.

In the volume I published in 1971, *The Physician: A Man for All,* I felt I should pay homage to the numberless multitude of doctors and health workers I have seen with my own eyes living out their profession with the love proper to a vocation. Twenty years later, in the volume entitled *That Breath Upon the Clay,* I devoted a section to the topic "Why I Believe in Medicine," attempting therein a Christian reading of the Hippocratic Oath.

In his Address to the Second International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers in 1987, devoted to "The Humanization of Medicine," John Paul II stated, "Even a superficial gaze at the history of medicine allows us to notice a singular continuity between human and Christian values, thanks to whose interaction that patrimony of civilization and progress which constitutes the pride of medicine has gradually been formed" (*op. cit.*, p. 7).

The great artists and scientists have been such not just on account of their talent and professional preparation, but because of the love they have nourished for the art and science cultivated.

I do not have specific statistics available—and they certainly do not exist or are doubtful—but I believe that of all professions, the choice of the medical profession nearly always reflects a precise vocation. Whoever is a doctor well knows—because he either intuited it at the outset or learned it in spite of himself or through slow and painful maturation—that to be a doctor as one should, it is necessary to have the vocation. Only the vocation interiorizes the profession, causes it to be assimilated by the whole man. And for a profession involving nonconventional contact with what is truest in man—his suffering—labels crumble or must, at least, be left at the door. Siniavski's maxim is suitable for the physician: "A man becomes truly close and dear when he loses his official characteristics—profession, name, age—when he ceases even to call himself a man and reveals himself purely and simply as a 'nobody'" (J. Siniavski, *Pensieri improvvisi* —"Impromptu Thoughts"—Milan: Jaka Book, 1968, no. 41).

Albert Schweitzer, who was an exegete and musician of great talent, in full maturity chose to become a doctor and earned a degree in medicine at age thirty-

eight. To someone who asked him to summarize the motive for his choice in a few words he replied, "Respect for life."

The medical profession, then, is not just a vocation, but a very lofty vocation, since it assumes the form of a service to the noblest cause: to serve life. In less general terms, I would say that such a vocation has at its root three fundamental motivations: the authentic wish to place oneself at the service of mankind, an elevated moral consideration of suffering, and becoming aware of the most thoroughgoing availability for a task which can often border on the supernatural. In choosing the medical profession, contingent motivations certainly exist, but these cannot and must not predominate.

There is, however, another reason which ought to spur the doctor to love his profession and to be aware that only by loving it can he practice it in worthy fashion. This reason is the trust everyone has in him.

As I have often repeated, there are a thousand doors which each of us hopes to find open one day or another; but there is one door which we would never want to find closed—the doctor's.

Love for medicine is right and proper as a response to the even excessive trust of man in the doctor and medicine. No one has greater access to man, to all men, than the doctor. The priest himself must approach with discretion where he has not been called; indeed, he is sometimes expressly rejected. Not the doctor, who, in practicing his profession, has no adversaries. The medical class is in a position to reach all, is believed and beseeched by all.

Personally, I am convinced that becoming aware of one's serious responsibility is not just a motive for concern, but, above all, a motive for confidence, a stimulus to love one's work.

Nowadays dialogue has been turned into a kind of obsession; we dress as lambs to speak with the wolves, hoping that these, once satiated, will accept confrontation; techniques for indiscriminate dialogue are discovered, with results for which a balance sheet would best be postponed.

The doctor, on the other hand, is unfamiliar with this problem, since he can count on the interlocutor with the best disposition in the world—the real or potential patient. The risk he faces, however, is not slight, for the patient asks a great deal of him, whereas he is often not in a position to give anything; indeed, if he were to be sincere, he would or might have to take away the patient's only hope.

I have wondered on several occasions: Can the doctor really find himself in the situation where he is of no help to the patient? I don't think so, and I am convinced that doctors should be fully persuaded and aware of a power which goes beyond the strictly technical exercise of their profession. The doctor who, in the school of experience, has learned a lesson of humanity possesses resources transcending those of a simple professional. He is the man who, more than every other, comes into contact with human suffering, which is never just physical suffering; where medicine does not bring relief the whole man cannot surrender—even if his physical vitality succumbs.

The true doctor, the one who loves medicine, never abandons his patient, much less when he recognizes that all medical assistance is by now useless. Precisely because he draws near man in what is most human in him, the doctor does not abandon the sick man when his illness proves to be incurable—while always treatable, however, on a psychic and spiritual plane. He does not abandon him because his vocation remains that of placing himself alongside those suffering to help them and travel the whole road of their infirmity.

If it is possible, desirable, and often observable that at the origin of the choice of the medical profession there stands a love, this love for medicine does not live on unearned income. Like every great love, love for medicine must also be defended, cultivated, and enriched. Those less young well know this, and the young must know it and not forget it.

The outstanding progress in medicine and its very socialization do not make it more difficult to cultivate this love, but they should facilitate this fundamental education. Everyone in fact recognizes the growing connection and interaction between medical and ethical problems —to the point that bioethics has now become an independent discipline. Within States and large hospital facilities ethics committees are progressively being constituted, called to pronounce on medical choices calling into play basic ethical principles. If medicine, by definition, is at the service of life, to love medicine amounts to loving life, from its conception to its natural close—all life and the life of all. Love for medicine, then, involves its ethicity, for love is the *ethos par excellence*.

The socialization of medicine, in spite of the risks of bureaucratization and impersonalism, has enlarged its field of action and, therefore, the demand for its presence in contexts requiring its increased humanization. A humanized and humanizing medicine is implemented only through a commitment at whose root there is a deep love for the service which medicine is called to perform. Under many aspects, this new reality is the fruit of the Christian conscience formed within our civilization. It is thus a question of a specific commitment by Catholic doc-

tors who, in a Europe without borders, represent—even in numerical terms—a force which is flanked by other organizations of health workers and substantial groups of volunteers

The doctors who are less young are called, with their witness, to arouse a deep love for medicine in the younger generations of doctors.

In the part of the Apostolic Letter *Salvifici Doloris* devoted to the figure of the Good Samaritan (nos. 28-30)—a text we might regard as the *Magna Charta* of the Catholic physician—John Paul II affirms, "Institutions are very important and indispensable; however, no institution can by itself replace the human heart, human compassion, human love, human initiative, when it is a question of dealing with the suffering of another This refers to physical sufferings, but is even more valid in the case of the multiple moral sufferings and when, in the first place, it is the soul which suffers" (*Salvifici Doloris,* 29)

The Association is not a good for its own sake which pours its value upon its members, but rather the sum total of the individual values which are associated The awareness that without love for medicine the adequate exercise of this most noble branch of knowledge cannot take place must enter into the outlook of young doctors and, particularly, their educators. And in order for this love to exist, the initial loving impulse which has led to this choice is not enough—it must be tenaciously cultivated, strengthened through trials, and radiated out by one's own testimony. This commitment has a serious urgency in a time like ours, marked by vast indifference following upon a deep crisis in values

To be a young doctor in a Europe without borders means to prepare oneself to live out one's vocation as a mission. And if Europe, for the purposes of a new evangelization, is regarded as a missionary land, it is also such for a medicine which, according to the desire and program of the World Health Organization, seeks to ensure health for all by the year 2000

For Pastoral Care Marked by Solidarity and Hope: The Church Responds to AIDS

A talk presented by Fr José L. Redrado Secretary of the Pontifical Council for Pastoral Assistance to Health Care Workers at the Symposium on AIDS organized by UNESCO in Venice June 8 1991

1. First of all, on behalf of His Eminence, Fiorenzo Cardinal Angelini, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, who has been prevented from coming by work commitments, and on behalf of the Office I represent as Secretary, I would like to address a cordial greeting to

— the Honorable Federico Mayor Garcia, Director General of UNESCO and his co-workers, promoters and organizers of this important event;

— the authorities and personalities representing the vital forces of science, art, culture, business, religion, and sports;

— all the other persons present at this meeting, not only to reflect on a topic of maximum importance and current interest, such as AIDS, but also to mark—through this movement of solidarity and cohesion—a new stage in achieving awareness of a situation which requires the mobilization and commitment of everyone at every level.

2. I am happy—and congratulate the Organizing Committee in this regard—with the unanimous spirit animating this meeting and with the multidisciplinary methodology at the sessions, an obligatory course for an approach to the phenomenon which we want to be immediate, adequate, and far-sighted. The experience of the Pontifical Council for Pastoral Assistance to Health Care Workers in dealing with health problems has confirmed the validity of this approach as the only course to be followed to arrive at positive results.

It is now the practice of our Office to expand its vision of problematics by availing itself of the collaboration and contributions of institutions and individuals belonging to different sectors of culture, science, political and social life, with no distinction based on religion, race, or continent

3. At the root of this "philosophy" is man, his suffering, which changes his face —a suffering face, but one which reveals and asks for love; man needs not only medical therapy, but also suitable care, respectful understanding, and full solidarity. For this reason, the Pontifical Council for Pastoral Assistance to Health Care Workers appreciates, supports, and is taking part in this significant event, whose purpose is to make us all in the various sectors jointly responsible, with a view

towards mobilizing necessary resources for AIDS research, information, and prevention

4. The Church has always regarded assistance to the suffering as an integral part of her mission.[1] AIDS constitutes a new field of human suffering and thus interpellates in particular fashion the Church, which has always considered suffering man as a "special way" for her magisterium and ministry.[2]

Since the appearance of the first AIDS cases, the Church has moved at all levels, seeking to adequately inform and educate the faithful and men of good will for responsible maturity and providing care for those affected. The letters of bishops, as well as the facilities for reception and treatment spread around the world at which religious, lay health professionals, and volunteers work, demonstrate the Church's involvement, collaboration, and solidarity with those suffering from AIDS.

5. *Solidarity* is the new name for the Church's pastoral care of AIDS victims. By solidarity the Church means not only the action carried out on a social level to find solutions together to serious, complex problems, but it also indicates, above all, with this term the intrinsic, indispensable exigency of the person, a being who *ex natura* is with-others and for-others. Solidarity represents the maximum social and moral expression of the Church's attention and pastoral action as regards AIDS victims and finds its foundation and measure in the dignity of the person.

6. Just as solidarity finds its ontological and ethical foundation in the dignity of the person, it also draws its content from the identity of man, a relational being in the double sense of being-with-others and being-for-others. The Second Vatican Council stresses this content in asserting that man "is the only creature that God has wanted for itself" and that "he cannot find himself fully except through a sincere gift of himself."[3]

7. Consequently, and on a practical level, solidarity calls for social commitment by all forces and responsibility shared by people and institutions to defend the healthy and not ghettoize the sick. It is imperative to seek and find solutions worthy of man and in a spirit of solidarity to the serious juridical, labor, moral, and religious problems, such as screening and keeping files, the presence of seropositive people at the workplace and the school, and community life in its varied forms. As beings-for-others, AIDS patients have a right—as, moreover, every other patient does—to receive care and assistance from the community. It is a universal exigency, above and beyond denominations, races, countries, and cultures. But not only ought they to receive, benefit from, the community's help in a passive way: the persons at whom the care of others is aimed can and must themselves speak and give to others, inasmuch as they are also protagonists in mankind's struggle against AIDS.

8. The forms of solidarity to be implemented are varied. At an initial level, we have the solidarity of persons according to their position and role. In his historic address to the Fourth International Conference, held at the Vatican in 1989, on the AIDS problem, the Holy Father insisted on this form of solidarity, recalling scientists, parents, teachers, young people, and public officials to their respective responsibilities. Many still vividly remember his afflicted concern, expressed to AIDS victims in these words: "Brothers and sisters in Christ, you that are familiar with all the harshness of the Way of the Cross, do not feel alone. With you is the Church, the sacrament of salvation, to sustain you on your difficult path. She receives much from your suffering, confronted in faith; and she is close to you with the comfort of the active solidarity of her members, so that you will never lose hope. Do not forget Jesus' invitation: 'Come to me, all who are weary and weighed down, and I will give you rest' (*Mt* 11:28)."[4]

9. The solidarity of values and exigencies is indispensable, since the connection between the appearance and unfolding of this disease and human behavior conditioned by a serious crisis in values has been demonstrated. It was not fortuitous that the Holy Father, in his address to those attending our Fourth International Conference, devoted to AIDS, did not hesitate to call everyone's attention to the ever-growing danger of *immunodeficiency on the level of existential values,* a genuine pathology of the spirit requiring adequate social, moral, and spiritual therapy.[5] It is a question of a positive ideal, and in this perspective moral norms of conduct should be comprehended and applied. Our struggle will be effective if it seriously takes into consideration the moral and spiritual values and exigencies of AIDS victims.

10. Institutional solidarity challenges institutions: Church, civil society, the public and private domains, scientific-technical institutions, medical associations and groups, health professionals, volunteers, and hospitals. In having available more means and persons trained and involved in varied fields, institutions are in a position to make a notable contribution to the fight against AIDS. The organizational and planning capacities for mobilization and conscientiousness on a worldwide scale should be added to these means and resources. Precisely because they are powerful and able to do good to those suffering, institutions cannot lose sight of the good of man—of every man and all men—in their work. The risk of reducing man to a means is otherwise great, to the detriment of humanity, man's dignity as a person.

11. Worldwide solidarity, in addition to being a need deriving from the fact that all countries, all peoples, and all continents are affected, is a moral exigency spurring men—equal in dignity—to commit themselves in a solidary way to constructing this civilization of love, in which the rights and social, juridical, political, moral, and religious freedoms of all the children of God, created in his image and likeness, will be recognized and protected. In this form of society, the attention and aid to be given to the least fortunate countries and continents are situated. The good of man, his dignity, must spur solidarity with the lands which rightly await concrete, effective solidarity from the richest

continents With AIDS, the imperative becomes even more categorical

12. AIDS patients and their relatives and friends expect from the Church a word of hope, or, rather, a witness of hope. They hope to find faithful companions among us, to be protected against all forms of segregation and discrimination, to encounter real friends to accompany them through life as far as death The Church is seeking to respond to this important challenge with *the word of hope against all hope* of her Founder and Master and with the daily commitment and concrete solidarity of bishops, priests, men and women religious, and lay people, who form an authentic army of witnesses to the Church's new hope for AIDS victims.

13. The Church's attention particularly turns to the young, who are the hope of the world and of the Church. The threat hanging over the younger generations is an additional reason to work together with a view towards ensuring a future of hope for mankind Experience teaches that the only way to foresee the future is to prepare it. I shall conclude my talk with the Pope's message and hope for the young: "Be leaders in building a just social order on the basis of which the world of the future can be governed. With generosity and rich imagination, practice ever-new forms of solidarity. Be close to the least fortunate, to those who suffer, cultivating the virtue of friendship and understanding, rejecting all violence against yourselves and others. May your strength be hope, and your ideal, the universal affirmation of love." [6]

[1] Cf. John Paul II, Motu Proprio *Dolentium Hominum*. February 11, 1985, no. 1.

[2] Cf. John Paul II, Apostolic Letter *Salvifici Doloris*. February 11, 1984, no. 3

[3] Second Vatican Council, Pastoral Constitution *Gaudium et Spes*, no 24.

[4] John Paul II, Address to the Fourth International Conference organized at the Vatican by the Pontifical Council for Pastoral Assistance to Health Care Workers, in *Dolentium Hominum*, no 13 (1990), p 7

[5] *Ibid*. p. 7

[6] *Ibid*. p. 8

Trips

Valhalla, New York

The New York Medical College granted Cardinal Angelini an Honorary Doctorate in human sciences in medicine ("Humane Letters")

The ceremony took place at the prestigious "medical school in the Catholic tradition," located in Valhalla, New York, on January 31, 1991. Cardinal Angelini was accompanied by Fr. Redrado, Secretary of the Council.

The New York Medical College throbbed that day with an atmosphere of science, experience, and celebration—it was plain to see on the faces of many distinguished professors clad in their gowns, with a ceremonial that was at once sober and solemn The Medical College is one of the oldest medical schools in the United States, founded in 1860. A private institution, it is the largest medical school in New York State, with 700 regular students and 500 in the process of specialization It is the only institution in the Hudson Valley Region devoted to biomedical research.

The merits of the new doctor were pointed out by both the ceremony program and the President of the Medical College when the moment came to award the degree—an extensive curriculum vitae at the service of life in its various manifestations, so rich and profound in Cardinal Angelini It was an honor to his person, to be sure, but also meant prestige for the Health Office he heads—prestige for the Church, as he himself so often repeats and as he had occasion to stress that same day in his words of gratitude during the reception which followed the ceremony, when he thanked University President John Cardinal O'Connor and particularly the Chancellor, Monsignor James Cassidy, linked to this Council not only as a Consultor, but by bonds of friendship as well

Patrick S. Smith and Malcolm Wilson also received Honorary Doctorates in Humane Letters along with Cardinal Angelini.

In addition, our stay in New York provided the occasion for other contacts, such as our visit to Terence Cardinal Cooke Hospital, where we saw AIDS and Parkinson's patients. We also visited Cardinal O'Connor, the Archbishop of New York, at his offices, exchanging impressions on pastoral care in the health field and on some of the current concerns of the Pontifical Council.

We concluded our trip with a reception offered by the Most Rev Raffaele Martino, Permanent Observer of the Holy See at the United Nations, on the occasion of the awarding of the honorary degree The officers of The New York Medical College attended this reception as well.

To all we convey our most sincere gratitude for the gestures of friendship and fraternal welcome offered us in this time.

FR JOSE L. REDRADO
Secretary
of the Pontifical Council
for Pastoral Assistance to Health Care Workers

MADRID

Health and Peace for Development and Democracy in Central America

Organization, Objectives, and Development

The Third Madrid Conference, devoted to "Health and Peace for Development and Democracy," gathered together the international community in Madrid, May 1-4, 1991, to achieve greater multilateral understanding of the Central American crisis, on the one hand, and to seek support for the projects included in the second phase of the Central American Health Initiative, on the other.

The Conference was held under the auspices of the Spanish Government in collaboration with the Pan American Health Bureau and the World Health Organization.

In attendance were representatives of the seven countries of the Central American isthmus and the Dominican Republic, other South American and Caribbean countries including those belonging to the Group of Eight, the governments of Europe, the United States, Canada, the Holy See, the European Economic Community, other intergovernmental organizations, and international and inter-American cooperation and credit agencies.

The representatives of the Central American countries described the region's socioeconomic and health situation and presented the four priority areas of the Initiative's second phase and their main components, consisting of the regional and national projects.

All those attending the Conference on Health and Peace for Development and Democracy exchanged views on the best way to implement the various projects to the utmost and ensure that the Health Initiative's realization would continue to strengthen peace and democracy.

Presence of the Holy See

The Delegation of the Holy See was headed by Fiorenzo Cardinal Angelini, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, and included Fr. José L. Redrado, Secretary of the Office, and Monsignor Luigi Bonazzi, Auditor of the Apostolic Nunciature in Madrid.

The presence of the Holy See took on specific relevance; two points, among others, are particularly significant:

— There is great concern in these countries over the lack of material resources, but at the same time one notes considerable sensitivity to human and religious values. In addresses by many ministers allusions to God and religion, and even praise for the participation of the Holy See, were not lacking.

— Cardinal Angelini was named Deputy Chairman of the Coordinating Board, whereby the Holy See's presence received recognition.

Cardinal Angelini stated, "This is the third time that I have attended the Madrid Conference as the representative of the Holy See. I have noted a considerable growth of interest in and awareness of the basic primary health problems and needs in the Contadora countries. I also admire the presence of other, non-Contadora countries which, moved by deep solidarity, are prepared to assist the neediest nations. The Magisterium of Pope John Paul II is rich in insisting upon, encouraging, and stressing this support of the neediest countries by those which have been most favored."

In the final address, Cardinal Angelini referred to the presence of the Church, particularly in the Contadora countries, and the priority of health problems, specifically recalling several passages from the Encyclicals *Sollicitudo Rei Socialis* and *Centesimus Annus*. He also stressed the immense work of information and cooperation carried out by the Pontifical Council in the health sector.

The Assembly made public the *Madrid III Declaration*, in which there is emphasis upon a commitment to peace and the improvement of health conditions; efforts by different nations; the conviction that health is a fundamental component of development, peace, and democracy; and recognition of the valuable assistance received from governments and nongovernmental organizations.

FR. JOSE L. REDRADO
Secretary
of the Pontifical Council

MOSCOW

Relations of Friendship and Cooperation

The visit to Moscow by a Delegation of the Pontifical Council, May 9-14, 1991, was in response to an invitation by the Health Minister of the Russian Republic, in collaboration with the Vice President of the Soviet of Ministers of that Republic, and the First Deputy Health Minister of the USSR. Last year's visit to Moscow, Leningrad, and Kiev was deeply appreciated and opened up a series of fruitful relations with our Office. This visit should be situated, then, in continuity with the preceding one.

Its purpose—for both the hosts and our Delegation—was to reinforce relations of friendship and collaboration, offer some concrete aid, and propose cultural exchanges related to the health sector.

The Pontifical Council's Delegation, headed by Fiorenzo Cardinal Angelini, the Council President, included Fr. José Luis Redrado, O.H., Secretary of the Council; Franco Splendori, M.D. and Dina Nerozzi, M.D., Consultors; and Mr. Luciano Fiordeponti, a health expert for our Office.

Summary of the Visit

The five days spent in Moscow were marked by the following moments.

1. *Meetings with Health Officials*

— Hon. I.I. Grebesceva, Vice President of the Council of Ministers of the Russian Federative Republic and responsible for social policy. In attendance were V.A. Voronzov, Advisor to the President of the Council of Ministers of the Russian Federative Republic, and Health Minister V.I. Kalinin. Our interlocutors stressed the importance of relations with the Holy See, both because of the chance for cooperation and because it is the first time in the modern history of the Russian government that the human person is the center of sociopolitical attention.

— Hon. A. Baranov, First Deputy Minister of Health of the USSR, who explained to us the positive consequences of perestroika for the health sector.

— Hon. V.I. Kalinin, Health Minister of the Russian Republic. The conversation was characterized by mutual congeniality, for it was

Minister Kalinin who was behind our invitation to Russia. Many current health problems in Russia were jointly examined, running from those of cultural value to the sphere of health care, medical and nonmedical personnel, and the urgent need for aid.

— Professor Pokrovski, President of the Academy of Medical Sciences, and a group of scientists to reach agreement on the area of cultural exchanges.

2. *Visits to Health Facilities*

— The Children's Hospital of the Russian Republic, with surgical and clinical sections especially equipped for kidney transplants

— Moscow's Hospital XV, one of the largest in the Russian capital, with 1600 patients and 3000 employees, among whom 500 are doctors and 1200 nurses, and a diagnostic center serving two-and-a-half million people a year.

— The Eye Microsurgery Clinic, founded and directed by A. Fyodorov, M.D. This world-famous facility is quite efficient and a pioneer in the field of ophthalmology. The hospital's structure and administrative, scientific, and professional organization resemble science fiction, to the point that it must be regarded as unique in the world. An uncommon dignity and nobility accompany its extraordinary efficiency.

— The Faculty of Medicine of Moscow's University II, where we were received by the Rector, the medical students, and some professors. In fulfillment of their wishes, the students were able to ask the President of the Pontifical Council many questions; he responded to all of them as he went about constructing a fraternal and lively dialogue. They dealt with subjects like medicine as a vocation and a mission, the Catholic Church's attention to the personhood of the patient, in whom Christ lives, the need for collaboration with the USSR at this precise moment, the aims of the Pontifical Council and its willingness to cooperate with all its capacity at the service of health policy and care in the entire Soviet Union as a practical demonstration of its determination to provide assistance with simplicity, discretion, and effectiveness.

3. *Meetings with Orthodox and Catholic Communities*

— Monsignor Pitirim, Metropolitan of Valokolansk and Iurievsk, responsible for the Moscow Patriarcate's public relations. The Metropolitan, who had been a member of parliament and occupied leading political posts, was very interested in pastoral care in health and warmly welcomed the invitation for Orthodox priests to visit Rome so as to become familiar with religious hospitals, pastoral practice among health workers, and spiritual and social assistance to the sick.

— The Eucharist was celebrated each day at Moscow's Catholic Church of St. Louis and, on one occasion, at the chapel of the community of Mother Teresa's Missionaries of Charity.

4. *Some Observations*

— In the context of this visit to Moscow, the Pontifical Council offered concrete technical aid and specific sociocultural exchanges to health officials and Metropolitan Pitirim.

— All our meetings brought out the importance our hosts attached to the Catholic Church and the action of the Holy See.

— Relations with local health officials were very open and sincere.

VENICE

UNESCO Meeting for the Fight Against AIDS

The Venice Meeting of June 8, 1991, organized by UNESCO, in collaboration with WHO and the world of science, brought together personalities and authorities representing the vital forces of science, culture, art, business, religion, and sports, for the purpose of launching from Venice a vast world movement for increasing awareness, cohesion, and solidarity in the struggle against AIDS.

The Pontifical Council for Pastoral Assistance to Health Care Workers was invited by the Director General of UNESCO, the Hon. Federico Mayor García, and authorized and encouraged to participate in this Meeting by Angelo Cardinal Sodano, Secretary of State. Our Council was represented by its Secretary, Fr. José Luis Redrado, O.H.; Monsignor Italo Taddei, Consultor; and Fr. Jean-Marie Mpendawatu, a staff member.

1. Opening Address

After the welcoming speeches by the Mayor of Venice and the Representative of the Venetian Region, the Hon. Federico Mayor García, Director General of UNESCO, brought out the whole process of the "Venice Appeal," the strategies UNESCO is trying to carry out, and the main objective proposed. The Director General manifested that some years ago UNESCO called upon the world to save Venice, which was threatened with destruction; today, he continued, UNESCO calls upon the world from Venice to save humanity, threatened by the plague of AIDS. This call emerges from the terrible situation created by the constant progression of the malady on all continents. Mankind is faced with a serious problem, not just involving public health, but development and civilization.

2. Scientific Research and the World AIDS Situation

Dr. Luc Montagnier, the representative of the group of scientists, stated that researchers were optimistic about the current status of research and treatment, where a great deal of work has been done. At present the first positive results obtained after a decade studying HIV are being consolidated.

Through the report by Dr. M.H. Merson, Director of the program to combat AIDS, WHO presented an epidemiological panorama of the virus' first decade, characterized by a geometrical progression of the illness, leaving us with a somber, troubling picture.

3. General Support for the Message of Solidarity

The statements of support by the vital forces attending and the signing of the "Venice Appeal" by their representatives as a gesture of backing for the initiative, provide evident proof that everyone has perceived the seriousness of the problem and the need to join together to fight effectively against this terrible disease. Collaboration and solidarity are essential, then, to increase awareness and mobilize human, technical, and economic resources for research, information, and prevention. To support the "Venice Appeal" means a commitment by each in his own field to disseminating the message of solidarity and generosity to be displayed by all at all levels in this worldwide struggle against a malady threatening all. In this spirit all the representatives expressed support for the initiative, and the Pontifical Council for Pastoral Assistance to Health Care Workers, through Fr. José Luis Redrado, its Secretary, conveyed its adherence and signed the "Venice Appeal."

Fr. JEAN-MARIE MPENDAWATU

APPEL DE VENISE

(Venise, 8 juin 1991)

Les signataires de cet appel, citoyens du monde, conscients et responsables, rassemblés à l'initiative de l'UNESCO,

Rappelant qu'au début des années quatre-vingt, la médecine et la science révélaient la brutale apparition sur la scène mondiale d'un nouveau virus, le VIH, qui cause le SIDA;

Constatant que depuis cette émergence, les statistiques ont tenu un langage implacable, l'OMS nous indiquant que plus de neuf millions d'adultes, dont six millions en Afrique subsaharienne, et un million d'enfants sont d'ores et déjà infectés par le virus, et que, selon les projections actuelles, quelque 40 millions d'hommes, de femmes et d'enfants le seront en l'an 2000;

Rappelant que dans la décennie à venir, plus de dix millions d'enfants naîtront porteurs du virus et que dix millions d'enfants perdront un de leurs parents du fait du SIDA;

Rappelant que la communauté internationale, les organisations intergouvernementales, gouvernementales et non gouvernementales cherchent à enrayer cette grave pandémie par le moyen du Programme mondial de lutte contre le SIDA, cordonné par l'OMS;

Soulignant que cette pandémie frappe plus particulièrement les pays en développement — et notamment les pays du continent africain — et aggrave ainsi la situation déjà difficile de millions d'hommes et de femmes, les atteignant dans leur dignité, dans leur intégrité physique et morale, dans leur capacité de vivre et de s'épanouir;

Notant, avec inquiétude, que la mort de millions d'adultes jeunes et d'âge moyen pourrait entraîner une véritable déstabilisation économique, sociale, voire politique dans de nombreux pays en développement, et surtout dans les pays les moins avancés;

Veulent rappeler au monde que, outre les ghettos de solitude, de souffrance et d'exclusion dans lesquels elle enferme des millions d'êtres humains, cette pandémie menace l'avenir de l'humanité en l'ébranlant dans ses fondements, que sont la stabilité des sociétés, le respect des cultures, la protection de l'environnement, le droit à l'éducation, la consolidation de la démocratie et l'aspiration au développement;

Souhaitent que la prise de conscience de cette menace favorise le renforcement de l'action entreprise par l'OMS en vue d'une mobilisation internationale, permettant la définition de politiques qui soient à la fois globales par leur interdisciplinarité et particulières dans le respect qu'elles porteront aux cultures, aux sociétés, aux peuples auxquels elles seront destinées;

S'appuyant à cette fin sur l'UNESCO, dont les domaines de compétence et la mission éthique la désignent pour contribuer, aux côtés de l'OMS, à l'élan de solidarité entre les nations, entre les peuples et entre les individus contre le SIDA;

Décident d'en appeler à la générosité des hommes et des femmes qui veulent témoigner de leur volonté de lutter contre le fléau en leur proposant de contribuer par leurs dons aux programmes nationaux de lutte contre le SIDA dans les pays les plus touchés d'Afrique, en particulier les moins avancés, afin de renforcer l'éducation préventive, la formation et la recherche scientifique et d'aider les orphelins, notamment par la prise en charge de leur frais de scolarité.

OTHER MEETINGS

Moscow

Fr. Bonifacio Honings, our Consultor, represented the Holy See at the First European Conference of the heads of anti-drug services (HONLEA), held in Moscow, November 19-23, 1990.

Rome

In Rome the Pontifical Council has taken part in several meetings, including

— the meeting of officers of organizations doing social-charitable work, organized by the Pontifical Council Cor Unum, February 7-8, 1991;

— the meeting organized by the Pontifical Council Iustitia et Pax, March 5, 1991, attended by representatives of the Departments of the Roman Curia;

— two encounters sponsored by the Pontifical Council for the Unity of Christians, on May 2 and June 18, 1991, to reflect with several representatives of the Curia Departments on ecumenical activity;

— the meeting organized by the Pontifical Council for Dialogue with Nonbelievers, May 16, 1991, which dealt with the topic of "How to Believe in God Today";

— the first training course for health workers organized by the Dermopathic Institute of the Immaculate Conception every Monday from November to March;

— a day-long session devoted to transplants organized by the Federation of Italian Pharmacists, February 26, 1991

Verona

In the framework of the event designated as "Italiafarmacia 1991," a day of reflection was held on April 27, organized by the Catholic Pharmacists of Italy. Fr. Redrado represented the Pontifical Council and addressed those attending, stressing some ethical values of the profession and the nature of professionalness

Geneva

Monsignor Italo Taddei, our Consultor, took part in the annual meeting of the World Health Assembly, May 6-17, 1991.

Mirano (Venice)

On June 1, 1991 Fr. Jean-Marie Mpendawatu, a staff member of our Council, took part in the presentation of the book *Health Policy for Man*

PONTIFICIUM CONSILIUM DE APOSTOLATU
PRO VALETUDINIS ADMINISTRIS

VI^ème CONFERENCE INTERNATIONALE
SIXTH INTERNATIONAL CONFERENCE

DROGUE ET ALCOOLISME CONTRE LA VIE
DRUGS AND ALCOHOLISM AGAINST LIFE

GRANDE SALLE DU SYNODE - CITÉ DU VATICAN - 21-22-23 NOVEMBRE 1991
VATICAN CITY SYNOD HALL - NOVEMBER 21-22-23, 1991

The Program of the Sixth International Conference

The Sixth International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers seeks to deal with the serious and widespread phenomena of drugs and alcoholism in scientific and ethical terms, but with a constructive, hopeful purpose

Scientists, researchers, sociologists, anthropologists, moralists, and experts in prevention and care in their papers and remarks will offer an analysis of alcoholism and of the abuse of psychotropic substances in terms of individual, family, and social causes, with the rigorous support of the latest statistical data and making reference to the hardest-hit areas, the age groups involved, and the therapeutic instruments which are most suitable both at present and with a view towards future action

Dugs and alcoholism are phenomena which, when coming up against medical science and practice, have already traveled a long way. Consciously or unconsciously, the alienation sought through recourse to drugs and alcohol is fueled by the crisis in basic ethical values which is prompted, especially in the young, by insufficient training, conditioning by illusory or inadequate role models, the crisis in the institution of the family, and disdain or lack of consideration of ideals whose attainment requires sacrifice and dedication. Moreover, the drug phenomenon in particular is, paradoxically, favored by the speed of current means of communication, modern techniques for the synthetic transformation of natural substances, consumerism, and the availability of ready money. At the same time, however, the spread of drug addiction and alcoholism confirms a build-up of anxieties and needs to which society is either unwilling or unable to respond.

The motto for this Sixth Conference—"Hoping against Hope"—is directed towards examining the phenomena of drugs and alcoholism by situating them within the vaster domain of the values and fundamental rights of the human person, the ultimate reasons which can and must spur human beings to accept and love their lives in terms of both fulfillment of their deepest aspirations and service to others.

Drugs and alcoholism affect a growing number of persons but must involve everyone so that evil, instead of being repressed, will be overcome by good.

FIORENZO CARDINAL ANGELINI

Thursday November 21, 1991

9:00
Commencement of Conference
FIORENZO Cardinal ANGELINI

9:20
Opening Address
ALFONSO Cardinal LÓPEZ TRUJILLO
President of the Pontifical Council for the Family

Chairmen:
Professor MANUEL VELASCO SUÁREZ
Director of the National Neurology and Neurosurgery Institute, Secretary General of the National Health Council, Mexico

Hon ADRIANO BOMPIANI
President of the National Commission on Bioethics, Member of the Senate, Italy

Use, Abuse, and Dependence
Hon HERBERT KLEBER
Deputy Director for Demand Reduction, Office of National Drug Control Policy, USA

10:00
Andean Cocaine: Historical and Cultural Aspects
Professor GABRIEL GARCÍA MÁRQUEZ
Nobel Prize Winner for Literature, Columbia

10:20
The East and the Opioids: A Historical Perspective
Dr. CHAVALIT YODMANI
Secretary General of the Narcotics Control Department, Thailand

10:40
Drugs and Destruction of the Social Fabric
Professor MICHEL SCHOOYANS
Professor of Political Philosophy, Contemporary Ideology, and Social Ethics at the University of Louvain, Belgium

11:00
BREAK

11:10
Chairmen:
Professor ALFRED HILDEBRANDT
Regional Director at the Pharmacy Institute, Germany

Dr. MARIO PENDINELLI
Director of *Il Messaggero*, Rome

How Epidemiology Helps Us to Grasp the Phenomenon of Drug Addiction
Dr. LLOYD JOHNSTONE
Director, Monitoring the Future, Institute for Social Research, University of Michigan, USA

11:30
Alcoholism: Sociocultural Aspects and Spirituality
Professor YURI LISITSIN
Academician of the USSR Academy of Medical Sciences

PRESIDENCY

Fiorenzo Cardinal Angelini
President of the Pontifical Council for Pastoral Assistance to Health Care Workers

H.E. Professor Giovanni Battista Marini Bettolo
President of the Pontifical Academy of Sciences

11:50
Alcoholism: A Challenge to the United Nations
Dr Jacek Morawski
Director for the Prevention of Alcohol and Drug Problems in the International Organization of Good Templars, Poland

12:10
Alcoholism, Personal Morality, and Popular Movements
Dr. Helge J Kolsiad
International Organization of Good Templars, Norway

12:30
Psychoactive Drugs Used in Therapy Subject to Abuse
Professor Bruno Silvestrini
Professor of Pharmacology and Pharmacognosy at La Sapienza University, Rome

13:00
BREAK

15:00
Chairman:
Professor Fr Krzysztof Szczygiel
Director of the Bioethics Institute at the Pontifical Theological Academy of Cracow, Poland

Alcohol, Drugs, and an Anti-Life Mentality
Professor Gonzalo Herranz
Member of the National Committee for Anti-Drug Coordination, Chairman of the National Medical Ethics Commission, Spain

15:20
Convergence of Religiosity and Spirituality for the Dignity of the Person
Professor Elio Toaff
Chief Rabbi of the Jewish Community in Rome

15:40
Sobriety: A Challenge to the Culture of Pleasure
Professor John Haas
Professor of Moral Theology at St. Charles Borromeo Seminary, Overbrook, Pennsylvania, USA

16:00
The Concept of Disease in Alcoholism and Drug Addiction
Professor Roger Meyer
Director of the Alcoholism Research Center, Department of Psychiatry at the University of Connecticut, USA

16:20
BREAK

16:40
Chairmen:
Professor Joseph E Murray
Nobel Prize Winner in Medicine, USA

Professor Francesco Antonio Manzoli
General Director of the Italian Superior Institute of Health

The Genetic Basis for Alcoholism
Professor Bernard Hillemand
Professor of Therapeutics at the University of Rouen, France

17:00
Reflection on the Alcohol-Fetal Syndrome
Professor Jérôme Lejeune
Member of the Pontifical Academy of Sciences, Professor of Fundamental Genetics at the University of Paris

17:20
Determinism and Freedom: The Drug Problem
Professor Julián Marías
Member of the Royal Academy of the Spanish Language, Spain

17:40
Hidden Alcoholism
Professor Jean-Paul Rousseaux
Director of the Psychopathology Service at the St. Luke University Clinics of the Catholic University of Louvain, Belgium

18:00
Somatic Disorders in Alcohol Abuse
Professor Charles S. Lieber
Director, Alcohol Research and Treatment Center, Bronx, New York, USA

Friday November 22

9:00
Chairmen:
Dame Sheila Sherlock
Emeritus Professor of the Royal Free Hospital School of Medicine, London

Professor Duilio Poggiolini
Director General of the Pharmaceutical Service at the Italian Ministry of Health

The Difficulties in Early Diagnosis of Alcoholism
Professor Alessandro Bertia Anguissola
President of the Italian Institute of Social Medicine

9:20
Alcohol and Marginalization: Sociological and Pastoral Aspects
Msgr James Cassidy, Ph. D.
Chancellor of the New York Medical College, Valhalla, USA

9:40
The Coexistence of Alcohol and Drug Use and Mental Illness
Professor Frederick K. Goodwin
Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, Washington, D.C., USA

10:00
The Nature of Drug Addiction and Scientific Research
Professor Floyd E. Bloom
Director of Preclinical Neuroscience and Endocrinology at the Scripps Clinic and Research Foundation, La Jolla, USA

10:20
Effects of Drug Use on the Newborn
Professor Antonia Novello
Surgeon General of the Public Health Service, Washington, D.C., USA

10:40
BREAK

11:00
Chairmen:
Dr. Keith Jones
Director, Medicines Control Agency, Department of Health and Social Security, London

Professor Marat Varianian
Member of the USSR Academy of Medical Sciences, Director of the Research Center of Psychic Health, USSR

Adolescence, Drug Addiction, and Environment
Dr. François Rüegg
Secretary of the Catholic International Children's Bureau, Switzerland

11:20
The Personality and Sociocultural Profile of the Drug Addict
Professor Maurau Cavalcanie
Professor of Psychiatry and Anthropology at the University of Fortaleza, Brazil

11:40
Drugs and Sexual Freedom
Msgr. Elio Sgreccia
Director of the Bioethics Center of the Faculty of Medicine and Surgery at the Catholic University of the Sacred Heart, Rome

12:00
Alcohol, Drugs, and the Value of the Human Body
Fr. Bonifacio Honings, O.C.D.
Professor of Moral Theology at the Lateran Pontifical University, Rome

12:20
Drug Addiction and Inner Suffering
Professor Ferruccio Antonelli
President of the Italian Society for Psychosomatic Medicine, Italy

12:40
Acute Intoxication from Psychoactive Substances: Diagnostic and Therapeutic Aspects
Professor Corrado Manni
Director of the Anaesthesia and Resuscitation Institute at the Catholic University of the Sacred Heart, Rome

13:00
BREAK

15:00
Chairman:
Professor Adolfo Turano
Director of the Microbiology Institute at the University of Brescia, Italy

Drug Addiction and AIDS
Professor Luigi Oriona
Director of the Institute for Infectious Diseases at the Catholic University of the Sacred Heart, Rome

15:20
The Prison Situation and Drug Use
Dr. Maria Claudia Di Paolo
Administrative Director of the Prison Police Department at the Italian Ministry of Justice

15:40
The Military Situation and Drug Use
Dr. Charles Pérez y Iestor
Director of the Medical-Psychological Center of the Vidal y Barraquer Foundation in Barcelona, Spain

16:00
Drugs and European Politics
Sir Jack Steward Clark
Chairman of the Commission for Drug Problems of the European Parliament, Great Britain

16:20
The Economic Implications of the World Drug Traffic
Dr. Juan Zárate
Director of Drug Policy, Peru

16:40
The Importance of Drug Demand Reduction in Producer Countries
Professor Hans Emblad
Director, Program of Substance Abuse at the World Health Organization, Switzerland

17:00
BREAK

Saturday November 23

9:00
Chairman:
Fr. Aires Gameiro, O.H.
Professor of Clinical Psychology at the Catholic University of Lisbon, Portugal

Role of the Family
Dr. Rafael Pich
Secretary General of the International Foundation for the Family, Spain

Role of the School
Professor Jorge Alberto Serrano
Head of the Child Psychopathology Service at the St. Luke University Clinics of the Catholic University of Louvain, Belgium

Role of the Church
Fr. Pierre de Parcevaux
Vice President of the National Union of Families for the Fight against Drug Addiction, France

Role of Health Care
Dr Hiroshi Nakajima
Director General of the World Health Organization, Geneva, Switzerland

Role of the Mass Media
Dr Joaquin Navarro-Valls
Director of the Press Office of the Holy See

Sports and Drugs
H.E. Mr Juan Antonio Samaranchs
President of the International Olympic Committee, Spain

10:30
BREAK

11:00
Chairman:
Professor Elio Guzzanti
Scientific Director of the Child Jesus Hospital, Rome

Values in Rehabilitation
Archbishop José Saraiva Martins
Secretary of the Sacred Congregation for Catholic Education

Role of Pharmacological Therapy
Dr Jérôme Jaffe
Associate Director for Treatment Policy, Office for Treatment Improvement, USA

Role of Psychotherapy
Professor Wanda Poltawska
Director of the Institute for the Theology of the Family at the Pontifical Theological Academy of Cracow, Poland

Role of Employment
Dr Franco Marini
Minister of Labor, Italy

Therapeutic Communities Around the World
Msgr. William O'Brien
President of the World Federation of Therapeutic Communities, USA

Alcoholics Anonymous
Fr William J Clausen
Member of the National Catholic Council on Alcoholism and Drug-Related Problems, Illinois, USA

ROUND TABLE

The Coordination of International Cooperation in the Struggle against Improper Trafic in and Use Of Drugs

Chairman: H.E Mr. Daniel Cabezas, Ambassador of Bolivia to the Holy See

H E Mr. Théodore Jean Arcand, Ambassador of Canada to the Holy See

H E Mr. Hernando Durán Dussan, Ambassador of Columbia to the Holy See

H E. Mr. Fermín Rodríguez Paz, Ambassador of Cuba to the Holy See

H.E Mr Emanuele Scammacca del Murgo, Ambassador of Italy to the Holy See

H E Mr Francisco José Fialos Navarro, Ambassador of Nicaragua to the Holy See

H E. Mr. Dilshad Najmuddin, Ambassador of Pakistan to the Holy See

H E. Mr Huberi Wieland Alzamora, Ambassador of Peru to the Holy See

H E. Mr. Henryk Kupiszewski, Ambassador of Poland to the Holy See

H E. Mr Jesús Ezquerra Calvo, Ambassador of Spain to the Holy See

H E. Mr Thomas Patrick Melady, Ambassador of the United States to the Holy See

H E. Mr Selçuk Korkud, Ambassador of Turkey to the Holy See

H E Mr Jurij Yevgenievic Karlov, Ambassador of the USSR to the Holy See

The Most Effective Therapy for Alcoholism
Fr Joseph C. Martin, S.S.
President of Ashley, USA

Drugs: A Provocation for Volunteers
Fr Mario Picchi
President of the Italian Center for Solidarity, Rome

12:30
BREAK

15:00
Chairman:
Professor Rita Levi Montalcini
Nobel Prize Winner In Medicine, Italy; Pontifical Academician

Drugs: The Global Problem of Mankind
Professor Valentin Pokrovski
President of the Academy of Medical Sciences, USSR

The Drug Addict's Antisocial Behaviour and the Law
Hon. Rosa Russo Jervolino
Minister for Social Affairs, Italy

Young People and Drugs
Hon. Federico Mayor Zaragoza
Director General of UNESCO, Paris

Drugs and Alcoholism: Against Civilization Among Peoples
Hon. Louis W. Sullivan, M D
Secretary of Health and Human Resources, USA
Hon. Dick Thornburgh
Attorney General of the United States of America

Unitary Action by Governments to Eliminate the Drug Phenomenon
Hon. Giulio Andreotti
President of the Council of Ministers, Italy

Drugs and Alcoholism: The Present and the Future
H M. Queen Sofia of Spain

Local Organizing Committee

Rev. José Luis Redrado Marchite, O.H.

Dr. Dina Nerozzi
Prof. Giuseppe Astegiano
Prof. Domenico Di Virgilio
Prof. Gaetano Frajese
Dr. Giampiero Gasparro
Dr. Gianluigi Gigli
Dr. Anna Maria Martelli
Dr. Franco Placidi
Prof. Mario Racco
Dr. Luigi Sinibaldi Prof. Franco Splendori
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GENERAL INFORMATION

The Conference sessions will be translated simultaneously into English, French, Italian, and Spanish.

All who wish to participate in the International Conference must register, in writing, no later than October 25, 1991.

To enter Vatican City, a personalized identification badge is necessary. You may obtain this identification card upon presentation of an official document at the Pontifical Council Office located on Via della Conciliazione, 3.

The entrance to the Synod Hall is from S. Uffizio Square (the left colonnade of St. Peter's Square).

Conference Secretariat

Via della Conciliazione, 3 - 00193 Roma (Italia) Phone: (06) 6896845; 6896793; 6896798 Telex: 2031 SANITPC VA - Fax: (06) 6896841

Beginning on November 21, 9 a.m., at the Vatican City Synod Hall—phone: 6984016.

The *Proceedings of the International Conference* will be available by April 1992. You may reserve a copy during the Conference sessions or by writing to: Pontifical Council for Pastoral Assistance to Health Care Workers, 00120 VATICAN CITY.