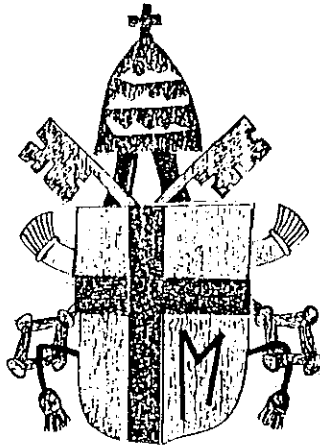

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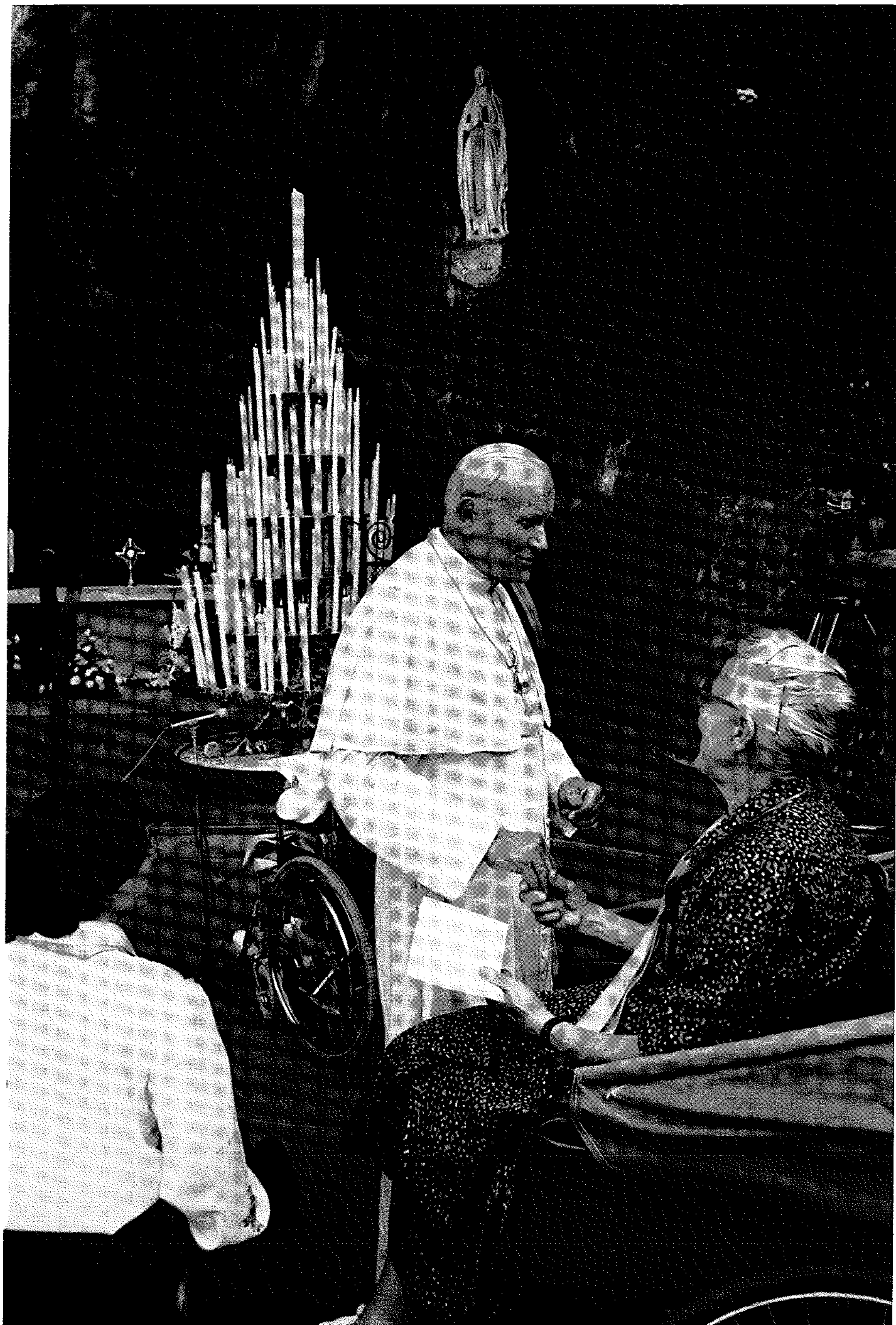
The illustrations in this issue have been taken from the book Pre-Colombian Medicine, *published by the Institute for Ibero-American Cooperation on the occasion of the 500th Anniversary of the discovery of the New World.*



MESSAGE OF THE HOLY FATHER JOHN PAUL II for THE FIRST WORLD DAY OF THE SICK 1993

Dear Brothers and Sisters,

1. The Christian community has always paid particular attention to the sick and the world of suffering in its multiple manifestations. In the wake of such a long tradition, the universal Church, with a renewed spirit of service, is preparing to celebrate the first *World Day of the Sick* as a special occasion for growth, with an attitude of listening, reflection, and effective commitment in the face of the great mystery of pain and illness. This Day, which, beginning in February 1993, will be celebrated every year on the commemoration of Our Lady of Lourdes, for all believers seeks to be "an intense moment of prayer, sharing, offering suffering for the good of the Church, and a call for everyone to recognize in the face of our sick brother the Holy Face of Christ, who, in suffering, dying, and rising again, carried out the salvation of humanity" (*Letter Instituting the World Day of the Sick*, May 13, 1992, no. 3).

The Day seeks, moreover, to involve *all men of good will*. Indeed, the basic questions posed by the reality of suffering and the appeal to bring both physical and spiritual relief to the sick do not concern believers alone, but interpellate all mankind, marked by the limits of the mortal condition.

2. Unfortunately, we are preparing to celebrate this first World Day *in circumstances which are in some respects dramatic*: the events of these months, while bringing out the urgency of prayer to entreat divine aid, recall us to the duty of implementing new and swift measures to assist those who suffer and cannot wait.

Before the eyes of all are the very sad images of individuals and whole peoples who, lacerated by wars and conflicts, succumb under the weight of easily avoidable calamities. How can we turn our gaze from the imploring faces of so many human beings, especially children, reduced to a shell of their former selves by the hardships of every kind in which they are caught up against their will because of egoism and violence? And how can we forget all those who at healthcare facilities—hospitals, clinics, leprosariums, centers for the disabled, nursing homes—or in their own dwellings undergo the calvary of sufferings which are often neglected, not always suitably relieved, and sometimes even aggravated by a lack of adequate support?

3. Illness, which in everyday experience is perceived as a frustration of the natural life force, for believers becomes an appeal to "read" the new, difficult situation *in the perspective which is proper to faith*. Outside of faith, moreover, how can we discover in the moment of trial the constructive contribution of pain? How can we give meaning and value to the anguish, unease, and physical and psychic maladies accompanying our mortal condition? What justification can we find for the decline of old age and the final goal of death, which, in spite of all scientific and technological progress, inexorably remain?

Yes, *only in Christ*, the incarnate Word, redeemer of man and victor over death, *is it possible to find the satisfactory answer to such fundamental questions*.

In the light of Christ's death and resurrection, illness no longer appears as an exclusively negative event—rather, it is seen as a "visit by God," an opportunity "to release love, to make works of love towards one's neighbor arise, to transform all human civilization into the civilization of love" (Apostolic Letter *Salvifici Doloris*, 30).

The history of the Church and of Christian spirituality offers very broad testimony of this. Over the centuries shining pages have been written of heroism in suffering accepted and offered in union with Christ. And no less marvelous pages have been traced out through humble service to the poor and the sick, in whose tormented flesh the presence of the poor, crucified Christ has been recognized.

4. The World Day of the Sick—in its preparation, realization, and objectives—is not meant to be reduced to a mere external display centering on certain initiatives, however praiseworthy they may be, but is intended to reach consciences to make them aware of the valuable contribution which human and Christian service to those suffering makes to better understanding among men and, consequently, to building real peace.

Indeed, peace presupposes, as its preliminary condition, that special attention be reserved for the suffering and the sick by public authorities, national and international organizations, and every person of good will. This is valid, first of all, for developing countries—in Latin America, Africa, and Asia—which are marked by serious deficiencies in health care. With the celebration of the World Day of the Sick, the Church is promoting a renewed commitment to those populations, seeking to cancel out the injustice existing today by devoting greater human, spiritual, and material resources to their needs.

In this regard, I wish to address a special appeal to civil authorities, to men of science, and to all those who work in direct contact with the sick. May their service never become bureaucratic and aloof! Particularly, may it be quite clear to all that the administration of public money imposes the serious duty of avoiding its waste and improper use so that available resources, administered wisely and equitably, will serve to ensure prevention of disease and care during illness for all who need them

The hopes which are so alive today for a humanization of medicine and health care require a more decisive response. To make health care more humane and adequate it is, however, essential to draw on a transcendent vision of man which stresses the value and sacredness of life in the sick person as the image and son of God. Illness and pain affect every human being: love for the suffering is the sign and measure of the degree of civilization and progress of a people.

5. To you, dear sick people all over the world, the main actors of this World Day, may this event bring the announcement of the living and comforting pre-

sence of the Lord. Your sufferings, accepted and borne with unshakeable faith, when joined to those of Christ take on extraordinary value for the life of the Church and the good of humanity.

For you, health workers called to the highest, most meritorious and exemplary testimony of justice and love, may this Day be a renewed spur to continue in your delicate service with generous openness to the profound values of the person, to respect for human dignity, and to defense of life, from its beginning to its natural close.

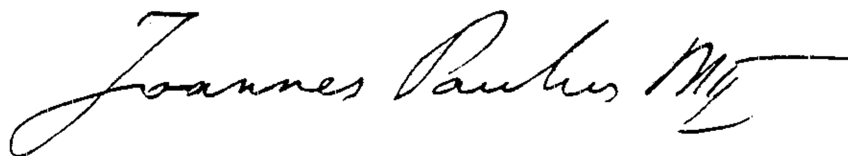
For you, Pastors of the Christian people, and to all the different members of the Church community, for volunteers, and particularly for those engaged in the healthcare ministry, may this World Day of the Sick offer stimulus and encouragement to go forward with fresh dedication on the way of service to tried, suffering man.

6. On the commemoration of Our Lady of Lourdes, whose sanctuary at the foot of the Pyrenees has become a *temple of human suffering*, we approach—as She did on Calvary, where the cross of her Son rose up—the crosses of pain and solitude of so many brothers and sisters to bring them comfort, to share their suffering and present it to the Lord of life, in spiritual communion with the whole Church.

May the Blessed Virgin, "Health of the Sick" and "Mother of the Living," be our support and our hope and, through the celebration of the Day of the Sick, increase our sensitivity and dedication to those being tested, along with the trusting expectation of the luminous day of our salvation, when every tear will be dried forever (cf. *Is* 25:8). May it be granted to us to enjoy the first fruits of that day from now on in the superabundant joy—though in the midst of all tribulations (cf. *2 Co* 7:4)—promised by Christ which no one can take from us (*Jn* 16:22).

I extend my Blessing to all!

Vatican City, October 21, 1992.



The World Day of the Sick and *Pastores Dabo Vobis*

With the Apostolic Exhortation *Pastores Dabo Vobis* of March 25, 1992, John Paul II fulfilled the expectations of the 1990 Synod of Bishops on *"Priestly Formation in the Present Circumstances."*

The Holy Father, in this document, perhaps the longest in his supreme pastoral service, broadly assimilated the conclusions of the Synod Assembly (83 *Propositiones* are cited in the letter, along with numerous implicit references), the contributions made during its preparation, and personal statements by the Synod Fathers.

A sure, straightforward *guide* unequivocally delineating the priest the Church expects for today and tomorrow. The *Pastor* of the third millennium for "a Church 'urged towards the new evangelization' by faithfulness to the Spirit animating her and the exigencies of the world far from Christ, but in need of Him" (Art. 9).

In the complex, highly structured "layout," formation for *pastoral care in health* finds its proper and balanced place.

On May 13, 1992, in a Letter addressed to Cardinal Fiorenzo Angelini, President of this Pontifical Council, the Holy Father instituted the *World Day of the Sick*, to be celebrated each year on the liturgical feast of Our Lady of Lourdes, February 11.[1]

A passage in this *Letter* strikes us as relevant to the subject we are dealing with. The Pope writes that the annual celebration has "the manifest purpose [of]... involving the dioceses in particular... and, in short, to promote better understanding of religious assistance to the sick by diocesan and regular priests..." (no. 2).

The elements present in *Pastores Dabo Vobis* devoted to *pastoral care in health* which we shall now point out are only brief references and limited passages that nevertheless open up a field of boundless pastoral service to the sick which is native to the ministerial priesthood.

We deduce this from the passage containing the Pope's definition of the formation of the priest at the beginning of the document. He writes that "it is a continuation in time of the work of Christ, which the Evangelist Mark indicates with the words 'Jesus ascended the mountain, called to himself those he wanted, and they went with him. He named twelve to remain with him and also sent them to preach and gave them the power to cast out demons' (*Mk* 3:13-15)" (Art. 2).

Now it so happens that in the parallel passage Matthew writes that to the *Twelve* Jesus also gave the power "to heal every illness and infirmity" (10:1). The announcements of the salvation and care of the sick are closely united for the Evangelist Matthew. The deduction is logical: all priestly formation necessarily includes this aspect.

Key Elements

The first reference is found in the paragraph on "Spiritual Formation: In Communion with God and in Search of Christ." There is a literal citation here of a long passage in the Council Decree on priestly formation *Optatam Totius* (no. 8). Those responsible for forming candidates for the priesthood are instructed as follows, in terms of the essence of spiritual formation: "Let them be taught to seek Christ[...]*in the Bishop who sends them and in the men to whom they are sent*, especially in the poor, the least, *the infirm*, sinners, and unbelievers...." (Art. 45).

This reference to the *Bishop*, as the person primarily responsible for formation, and to *the sick*, to whom he sends his priests, strikes us as highly significant. The *World Day of the Sick* is a providential yearly occasion to promote and implement this indication proceeding from the Synod and sanctioned by the Holy Father.

Indicating the places and services suited to a gradual experience of what a young candidate must one day take up as a par-

ticular, specialized ministry, the Pope writes, "The Synod Fathers have offered a series of concrete examples, *such as visiting the sick...*" (Art. 58). This is an explicit reference to *Propositio 28*,[2] to which the President of our Council made an excellent contribution through his statement before the participants, especially in the passage relating the Holy Father's words at the Angelus on Sunday, August 12, 1990.[3]

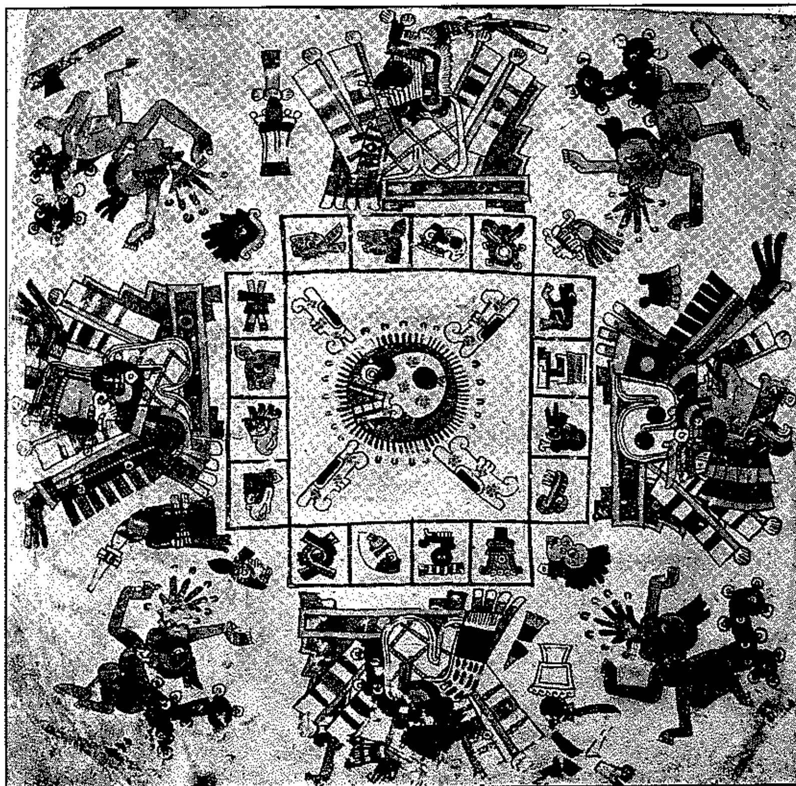
The *human dimension* of priestly formation is called the "first investigation" (Art. 72). Contact with man must lead him to mature and sharpen the sensibility required to comprehend, intuit, and take in even unexpressed needs, make oneself capable of encountering all and dialoguing with all.

"Particularly by knowing and sharing—that is, making one's own *the human experience of pain* in the multiplicity of its manifestation, *from indigence to illness*, from marginalization to ignorance, solitude, and material and moral poverty—the priest enriches his humanity and makes it authentic and transparent in growing, impassioned love for man" (*ibid.*).

This human formation will receive help from Christ the Lord, who has expressed his *charity as the Good Shepherd* not only with the gift of salvation, but by sharing the lives of those at his side. Accordingly, "the Word who became 'flesh' (cf. *Jn* 1:14) has wished to know joy *and suffering*, experience weariness, share emotions, console affliction..., *restore sick or dead children to their parents, weep over the loss of Lazarus...*" (*ibid.*).

In the part of the document devoted to the permanent formation of the priest (chapter VI), the Holy Father also devotes delicate attention to "those priests who, because of advanced age are referred to as *elderly...* [and to the] priests who *because of exhaustion or illnesses find themselves in a condition of physical weakness or moral weariness...*" (Art. 77).[4]

The Pope gives assurance that permanent formation will help them to live out consistently what they have taught, in union with the Suffering Christ, "reliving the experience of Paul, who said, 'I am joyful about the sufferings I bear for you and complete in my flesh what is lacking in the sufferings



of Christ, for the good of his Body, which is the Church' (*Col* 1:24)" (*ibid*).

A serious commitment to permanent formation is not easy for those engaged full-time in pastoral service, the Holy Father recognizes. But "*the sharing of life by the priest and the community*, if wisely conducted and utilized, constitutes a fundamental contribution to permanent formation ..." (Art. 78). It is through the whole ministry and life of the priest that aid comes.

Among the many moments, it is stated that "the doubts, crises, and delays in the face of the most varied personal and social conditions, *the temptations towards rejection or despair in times of pain, illness, and death*.... are also fraternally lived out and suffered through in the heart of the priest, who, in seeking answers for others, is continually stimulated to find them first of all for himself" (*ibid.*).

Though it is not the sole meaning, we sense in this passage that John Paul II feels special attention to what concerns the sphere of pastoral care in health is useful and necessary for the priest on the road to maturity and depth.

Mary, Mother of Priests

The document concludes with a fervent prayer to "Mary, Mother of Jesus and Mother of Priests" (Art. 82).

The close is particularly endearing: "Mother of Jesus Christ, you were with Him at the beginning of his life, you sought the Master amidst the crowd, *you attended Him when He was upraised from the earth, consumed for the single eternal sacrifice, and you had John*, your son, close by, receive those called from the outset, protect their growth, accompany your sons in their life and ministry, Mother of priests. Amen."

The Holy Father has expressed his thought on several occasions concerning the root of the Motherhood of Mary for the priesthood. He considers that every priest finds in John the *foundation of the communion* of life which is established between him and Our Lady by virtue of the words of the dying Jesus.[5]

A gift of exceptional and fundamental importance for ministerial priestly service, for it occurred at the moment when, "on effecting redemption through suffering, Christ at once elevated human suffering to the level of redemption."[6]

As a result, every priest, through this *testament-act of entrusting by the one eternal Priest* (cf. *Heb* 7:22-28), must constantly bear in mind the message coming down from Golgotha: "The Church, which arises from the mystery of redemption on the Cross of Christ, is bound to seek an encounter with man particularly on the way of his suffering. In this encounter man 'becomes the way of the Church,' and this is one of the most important ways."[7]

It is with Her, the Mother of the "Man of Sorrows" (cf. *Is* 53:3), that the priest must remain alongside the bed of every man who suffers and dies. And it is in harmony with Mary that the priest must become aware of that divine truth of salvific pain which every creature must live out, stimulating himself and the souls entrusted to him to fulfill the way of faith and hope.

The decision to establish the celebration of the *World Day of the Sick* on the liturgical feast of Our Lady of Lourdes is also rooted in this. John Paul II writes the following in the Letter instituting it: "Indeed, 'together with Mary, the Mother of Christ, who remained at the foot of the Cross, we pause alongside all the crosses of man today' (*SD*, 31). And Lourdes, one of the Marian sanctuaries dearest to the Christian people, is at once a place and symbol of hope and grace under the sign of the acceptance and offering of salvific suffering" (no. 3).

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

[1] Cf. *Dolentium Hominum - Church and Health in the World*, Journal of the Pontifical Council for Pastoral Assistance to Health Care Workers, Vatican City, no 20 (1992).

[2] "... Praxis pastoralis alumnorum praesertim evolvatur in paroeciis. Ut valde opportuna *commendatur* praxis visitationis infirmorum."

[3] Cf. FIORENZO Cardinal ANGELINI, "*The Priest Is Called to Take the Savior's Sympathy to the Sick*," in *Dolentium Hominum*, no 15 (1990), p. 60, note 4.

[4] Cardinal Angelini, in one of the final sessions, sent from the Synod gathering "*an affectionate greeting to all the sick Bishops and priests around the world. They are spiritually in our midst in this Synod Hall. Their apostolate of suffering in body and spirit is certainly an intense invocation of Christ, the Eternal Priest, ut mittat operarios in messem suam.*"

[5] Cf. the Encyclical Letter *Redemptoris Mater*, no. 45, note 130.

[6] Apostolic Letter *Salvifici Doloris*, no. 19.

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

Magisterium

Médicos mexicanos informantes de B de Sahagún Ms

Excerpts from Addresses by the Holy Father

Message to the Catholic Physicians of Latin America

Many Ethical, Legal, and Social Questions Must Be Examined in Greater Depth

"There is still much to learn, but above all there are still many ethical, legal, and social questions which must be examined more deeply in the development of the surgical technique of organ and tissue transplants for therapeutic purposes" This was affirmed by the Holy Father on June 20, 1991, before a group of physicians participating in the first international congress on organ transplants, held in Rome. The Holy Father stigmatized as "a shameful abuse" trade in organs for transplants. Organs and tissue of the human body, he added. cannot be used as article for sale or exchange

Dear Friends,

1 The fact that the First International Congress of the *Society for Organ Sharing* is being held here in Rome gives me the opportunity to welcome you and to encourage you in promoting the goal which the theme of your Congress expresses: "World Cooperation in Transplantation." I thank Professor Raffaello Cortesini for his kind words of presentation, and I offer my good wishes for the success of the work in progress.

Among the many remarkable achievements of modern medicine, advances in the fields of immunology and of surgical technology have made possible the therapeutic use of organ and tissue transplants. It is surely a reason for satisfaction that many sick people, who until recently could only expect death or at best a painful and restricted existence, can now recover more or less fully through the replacement of a diseased organ with a healthy donated one: We should rejoice that *medicine, in its service to life, has found in organ transplantation a new way of serving the human family*, precisely by safeguarding that fundamental good of the person.

2. This splendid development is not, of course, without its dark side. There is still much to be learned through research and clinical experience, and there are *many questions of an ethical, legal, and social nature which need to be more deeply and widely investigated*. There are even shameful abuses which call for determined action on the part of medical associations and donor societies, and especially of competent legislative bodies. Yet in spite of these difficulties we can recall the words of the fourth century Doctor of the Church, Saint Basil the Great: "As regards medicine, it would not be right to reject a gift of God (that is, medical science), just because of the bad use that some people make of it...; we should instead throw light on what they have corrupted" (*Great Rules*, 55:3, cf. Migne, *PG* 31:1048).

With the advent of organ transplantation, which began with blood transfusions, man has found a way to give of himself, of his blood and of his body, so that others may continue to live. Thanks to science, and to the professional training and commitment of doctors and healthcare workers, whose collaboration is less obvious but no less indispensable for the outcome of complicated surgical operations, new and wonderful challenges are presented. We are challenged to love our neighbour in new ways; in evangelical terms, to love "to the end" (cf. *Jn* 13:1), yet within certain limits which cannot be e exceeded, limits laid down by human nature itself.

3. Above all, this form of treatment is inseparable from a *human act of donation*. In effect, transplantation presupposes a prior, explicit, free and conscious decision on the part of the donor or of someone who legitimately represents the donor, generally the closest relatives. It is a decision to offer, without reward, a part of one's own body for the health and well-being of another person. In this sense, the medical action of transplantation makes possible the donor's act of self-giving, that sincere gift of self which expresses our constitutive calling to love and communion.

Love, communion, solidarity, and absolute respect for the dignity of the human person constitute the only legitimate context of organ transplantation. It is essential not to ignore the moral and spiritual values which come into play when individuals, while observing the ethical norms which guarantee the dignity of the human person and bring it to perfection, freely and consciously decide to give a part of themselves, a part of their own body, in order to save the life of another human being.

4. In effect, the human body is always a personal body, the body of a person. The body cannot be treated as a merely physical or biological entity, nor can its organs and tissues ever be used as items for sale or exchange. Such a reductive materialist conception would lead to a merely instru-

mental use of the body, and therefore of the person. In such a perspective, organ transplantation and the grafting of tissue would no longer correspond to an act of donation but would amount to the dispossession or plundering of a body.

Furthermore, a person can only donate that of which he can deprive himself without serious danger or harm to his own life or personal identity, and for a just and proportionate reason. It is obvious that vital organs can only be donated *after death*. But to offer in life a part of one's body, an offering which will become effective only after death is already in many cases an act of great love, the love which gives life to others. Thus the progress of the biomedical sciences has made it possible lor people to project beyond death their vocation to love. By analogy with Christ's Paschal Mystery in dying death is somehow overcome and life restored.

To repeat the words of the Second Vatican Council: only in the mystery of the Incarnate Word does the mystery of man take on light (cf. *Gaudium et Spes*, 22: *Redemptor Hominis*, 8). The Death and Resurrection of the Lord constitute the supreme act of love which gives profound meaning to the donor's offering of an organ to save another person. For Christians, Jesus' offering of himself is the essential point of reference and inspiration of the love underlying the willingness to donate an organ, which is a manifestation of generous solidarity, all the more eloquent in a society which has become excessively utilitarian and less sensitive to unselfish giving.

5. Much more could be added, including a meditation on doctors and their assistants, who make possible this striking form of human solidarity. A transplant, and even a simple blood transfusion, is not like other operations. It must not be separated from the donor's act of self-giving, from the love that gives life. The physician should always be conscious of the particular nobility of this work he becomes the mediator of something especially significant, the gift of self which one person has made—even after death—so that another might live. The difficulty of the operation, the need to act swiftly, the need for complete concentration on the task, should not make the physician lose sight of *the mystery of love involved in what he is doing*.

Nor should the recipients of organ transplants forget that they are receiving a unique gift from someone else: the gift of self made by the donor, a gift which is certainly to be considered an authentic form of human and Christian solidarity. At the approach of the Third Millennium, in a period of great historic promise, yet one in which threats against life are becoming ever more powerful and deadly, as in abortion and euthanasia, society needs these concrete gestures of solidarity and self-giving love.

6. In conclusion, let us remember those words of Jesus narrated by the Evangelist and physician Luke: "give, and it will be given to you; good measure, pressed down, shaken together, running over. will be put into your lap" (*Lk* 6:38). We shall receive our supreme reward from God according to the genuine and effective love we have shown to our neighbour.

May the Lord of heaven and earth sustain you in your endeavours to defend and serve life through the wonderful means which medical science places, at your disposal. May he bless you and your loved ones with peace and joy.

Médicos taínos.

A Gospel Sign of Eternal Life!

On Tuesday, August 13, the Holy Father arrived in Krakow, Poland, where he first paid a visit to the tomb of his parents and brother and then proceeded to the pediatric hospital in the Prokocim section, where he dedicated the new ambulatory department. The Pope spoke in Polish and English.

Dear children who are staying in this hospital to regain your health! Together with you, I should like first and foremost to greet the President of the Republic and his wife, the distinguished representatives of the President of the United States, led by Mr. Edward Derwinski, and of the American Congress, accompanied by Mr. Dante B. Fascell. I greet the Members of the Administrative Council of the Project Hope Foundation, the representatives of its International Administrative Council, the representatives of the Polish Government, and the sponsors with their wives. I greet all the people here present. I greet all the workers of the Polish-American Institute of Pediatrics at the Medical Academy of Kraków, and the Representatives of this Academy with the Rector, Professor Andrzej Szczeklik, and all the guests who are present.

1. As you know, I am beginning the second phase of my pilgrimage this year to my country. This time I am on a pilgrimage *to Jasna Góra to meet the young people* who have come *from all over the world* on the occasion of their feast, at the feet of the Queen of Poland, the Mother of the Church.

On my pilgrimage from Rome to Częstochowa, I could not neglect Kraków and Wawel Hill, which is an important shrine in our history.

However, divine Providence *has guided my first steps* on the path of this pilgrimage to a hospital, and precisely to this hospital *for children*, thus to *a special shrine of human suffering*. So I thank God for this encounter! I thank the organizers and the children for their invitation. I do not consider my presence in this hospital merely a stopover, but a place to pause, a station in the religious and ecclesial sense; a meeting *of human persons with God*, with a particular mystery to be lived as a means of purification and preparation for the next station.

What is more purifying and what draws one closer to the holy, almighty God than *the suffering and sacrifice of innocent beings*? To pronounce such words, it is necessary to have the person of Christ, the Son of God, and his Paschal mystery in one's own heart, the mystery of redemption... "Because by your holy cross you redeemed the world."

And it is in such a spirit that St Paul accepted his own weaknesses, needs, distress, persecutions, for *"... in weakness, (God's) power reaches perfection"* (*2 Co* 12:9).

Human weakness integrated through faith in Christ's mystery becomes the source of God's power. Therefore, the apostle wrote: "For when I am powerless, it is then that I am strong" (*2 Co* 12:10).

Thus, when the suffering of a human—of all humans—which cannot be avoided is accepted in the spirit of faith, *it is the source of strength for those who are suffering and for others*, and it is a fountain of strength *for the Church*, for her salvific mission. This is why I so appreciate all my encounters with the sick; this is why I rely so much on the fruits of their pain and weakness.

Once again, I would like to pass on this truth to you, dear children who are in the hospital, and to your parents and those who love you, protect you, and care for you. I would like to pass it on to all my fellow countrymen who are suffering at home, in the hospitals and in the various clinics, and to all those who are sick and suffering throughout the world.

People fear suffering; they want to repel it, to avoid it at all costs, just as Christ himself feared his passion and death, and they not only have *the right but the obligation* to do so. Nevertheless suffering exists in the world and afflicts us.

I know, dear children, that you and your parents would like to receive me in your homes, or in a church or a school or even a playground, in good health and in your best form. Meanwhile, you have invited me to a hospital that temporarily substitutes for your real homes, so that you may go home to your families well. I wish you this health with all my heart and pray for it. I pray for the healthy sparkle in your eyes, for your joyful smiles, for your happiness. I pray, that in spite of your illness, you may feel at home in this hospital, that you may find people who love you, that you may meet skillful doctors, attentive nurses, and good friends.

In the most difficult moments, when you are feeling ill or depressed, *look at Christ crucified*, who is risen! His Mother stood beneath the Cross. Tomorrow I am going to Jasna Góra to this Mother, who is our Mother, and I will bring you to her; I will take her your suffering, your prayers, your wishes, and all that I wish for you.

2. We find ourselves in this sprawling hospital, which was brought to birth by love and human solidarity. *Much good is being done here*: people are being restored to health, restored to life. All of this is *an evangelical sign of eternal life* and a sign of God's summons of mankind to that life.

Just as Christ acted by using his divine power, so you act by using human science, skills and wisdom in union with his grace. For this reason your Institute is, as all such places are, a sign, a sign which gives witness to the dignity and worth of human life. It is a sign of concern for this life and is, in a certain sense, the human sign of the full measure of this life.

This Institute, in addition to its essential meaning, still plays a special role *as a symbol*. It began more than twenty-five years ago, at a time when division in the world was emphasized. *It began in spite of the ideological differences which divided the world* and even in defiance of the hostility incited in these later years between the East and the West. To put it better: This work has been accomplished on a higher level than all this. Along with other such works, it must speak with a loud voice to us and to all the world. *The good of mankind has become stronger than whatever is contrary to it. Human solidarity has triumphed over divisions and hostilities.* Therefore, I wish to express my gratitude; I wish to pay special homage to those who courageously began this work, to those who brought it to completion, and to those who are continuing to help it grow. At this moment, spiritually present before our eyes are all those children who have, in this hospital, regained their health and have returned to their homes and to a normal life.

And so, gratitude and commendation are due first to the American "Poland." In its midst *this idea arose and found support from the members of the House of Representatives*.

It is not possible to name all those who have particularly distinguished themselves in this project. I will, then, recall only one member of Congress, an eminent man of politics who served in the highest government responsibilities, a man so very dedicated to the American "Poland": Mr. Clement Zablocki of Milwaukee. I knew him personally and I conferred upon him a distinguished papal honor.

Needs have grown, and so this hospital has expanded.

The government of the United States has contributed directly to this expansion. It is worth recalling that Mr. Zablocki was present when the construction of the Institute for Rehabilitation began and that this Hospital was dedicated by the then Vice President of the United States, Mr. George Bush. I ask the members of Congress who are present here to convey to President Bush *my expression of deep gratitude*. In the course of expanding this large, modern hospital at Prokocim, principal support has come from the American Foundation *Project Health Opportunity to People Everywhere*. Hope! The government of the United States designated this foundation as the sponsor of the Pediatric Institute of the Academy of Medicine at Kraków. The first letters of the Foundation's name make up a very meaningful word: Hope. Hope—*nadzieja*! The Foundation's president is its founder, Doctor William Walsh, who is present here with his wife and his family. Serving as Director of the Polish

Máscara de médico kwakiutl.

program is his son, Doctor John Walsh, a faithful friend of Poland. He has put his whole heart into working for children. The beginnings and the history of this Foundation are very interesting, for it is a story of human sensitivity to the needs of others. The background for this story always remains *Christ's parable of the Good Samaritan*. Suffice it to say that Project Hope carries on a hundred programs, one of which takes place in Poland. In the future it plans to move into other countries: Czechoslovakia, Hungary, the Baltic nations, Yugoslavia, Bulgaria, and Romania. "May God reward and help them." Obviously many organizations and individuals participate in all this work; both public and private funds have been invested. We cannot fail therefore, to mention the contributions of Poland: its Government, and Institutions on various levels, as well as the Academy of Medicine at Kraków and the Director of the Polish American Institute of Pediatrics, Professor Jan Grochowski, who is present. I ask to be excused for naming only these few.

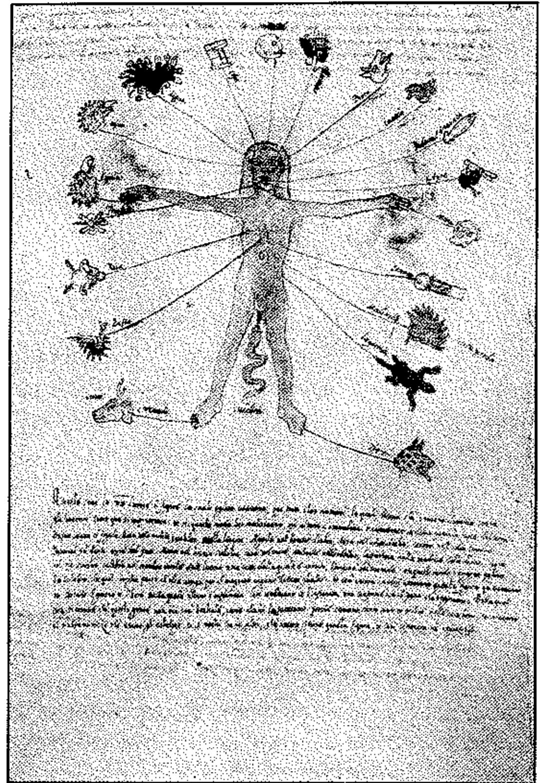
Thanks to this cooperation and solidarity we have now arrived at the last phase of this great initiative carried out by Project Hope—namely the *Ambulatory Care Center for Children*, which I blessed a few minutes ago. It will bear the name of that great friend of Poland, Clement Zablocki, whom I mentioned before. And this is not yet the end. There are also new projects under way for further developing this center. Among them, I am told, is the construction of a hotel for parents and children. Dear brothers and sisters, all of this is particularly significant because it tells us of the degree to which this hospital takes into account the many needs—physical and spiritual—of the human person.

It tells us that here, *not only are the latest advances in science and technology being employed, but there is also a concern for the human person as a whole.*

May God bless this undertaking and all others like it.

3. Dear ladies and gentlemen, dear brothers and sisters, in conclusion, may I share some memories and reflections with you.

From the very start of my pastoral service *I have been involved with the medical environment and the entire milieu of health care services.* Among those present today, I see the people I knew at the beginning of my pastoral work. There are those too



Influencias astrológicas sobre el cuerpo
Códice Vaticano 3738

Sacrificios y penitencias de los enfermos

whom I met as Archbishop of Kraków. Lastly, there are also the young people whom I am meeting for the first time. I have wished and still wish to remind all the healthcare staff of *their great vocation,* which derives from their service to the sick. In the Apostolic Letter *Salvifici Doloris* on the Christian meaning of human suffering, I wrote:

"How much there is of the Good Samaritan in the profession of the doctor, or the nurse, or others similar to them! Considering its 'evangelical' content, we are inclined to think here of a vocation rather than simply a profession" (no. 29).

There is no doubt that *the work of doctors and nurses*, and *any work among the sick,* is a service to Christ: "... as often as you did it for one of my least brothers, you did it for me" (*Mt* 25:40).

The nature of the help given to someone who is ill, of caring for him or her, implies that *we are dealing not* so much with a profession *as with a vocation* which, because of its nobility and ideals verges on the priestly vocation. In the fulfilment of such a vocation *religious values* play an enormous role. They reinforce *in the doctors and in all those who look after the sick*, the spirit of genuine service with regard to their patients, motivating and encouraging them to do their jobs in a way which is increasingly worthy of the profession; and they remind people of the greatest sense of responsibility for the good which has been entrusted to them, the human person. The *religious life, therefore, exercises its important role* through the way the doctor carries out his service and in the care of the sick in general. This is the place for what is called the apostolate for people who dedicate themselves to the service of the sick. It is meant to give them a deepened knowledge of the Gospel and the entire doctrine of the Church, and to help them in their moral and spiritual formation.

I thank you all once again. I thank the children for the programme they prepared for me, and I thank the little rose fallen from the basket; in spite of everything they conveyed their best wishes.

I thank you with all my heart for your good wishes and above all for the sacrifice of your suffering. I bear you with me to Jasna Góra, and at least from a distance, to future World Youth Days whose sites we do not yet know.

I bless you with all my heart.

The Sick Are Not a Burden!

On Tuesday, August 20 the feast of St Stephen the Pope went to St. Stephen's Basilica in Budapest, where he addressed many of Hungary's infirm and disabled people He called on Hungarians to reject a "subtly inhuman mentality."

Dear brothers and sisters,

1 I am grateful to God for this meeting with you on my first pastoral journey to Hungary, and it is with great affection that I offer you my cordial greeting. To all of you I express my best wishes for peace, hope, and consolation, in the Crucified and Risen Christ!

Saint Paul reminds us that "as in one body we have many members, and all the members do not have the same functions, so we, though many, are one body in Christ, and individually members of one another" (*Rm* 12:4-5).

During my pastoral journeys, I try to meet all the members of Christ's Mystical Body, in order to give recognition and honour to the respective mission of each one in the Church. To all of them goes my esteem, both for the service they offer for the sake of the Lord's flock, and for the clarity with which there shines in that service some aspect of the image of Christ. But in you, dear brothers and sisters whom I see before me, in you who suffer from some illness or infirmity or from advanced years, I recognize *a particular title of merit among the members of Christ's Body*, a title which in a way also belongs to all those who, standing at your side to help you, share in your sufferings through the bonds of blood or active charity

Your presence reminds me of the great host of all those in this country who are suffering like you and who perhaps have nobody close to them to provide not only necessary assistance but also the essential human support of sympathy and love. I would like to mention in particular the children abandoned by their parents and put into State institutions, where they cannot be given that atmosphere of tenderness and love which is so important for happy and harmonious growth With similar affection and understanding I think of all those who are handicapped, knowing that their suffering comes not just from the scars marking their body and spirit but also at times from not feeling accepted and respected by the other members of society.

2. At this moment of intense communion, dear brothers and sisters, I wish to say once more that in you and in them there shines forth, as in nobody else, communion with the mystery of Christ, the Crucified One, who by suffering out of love redeemed the world.

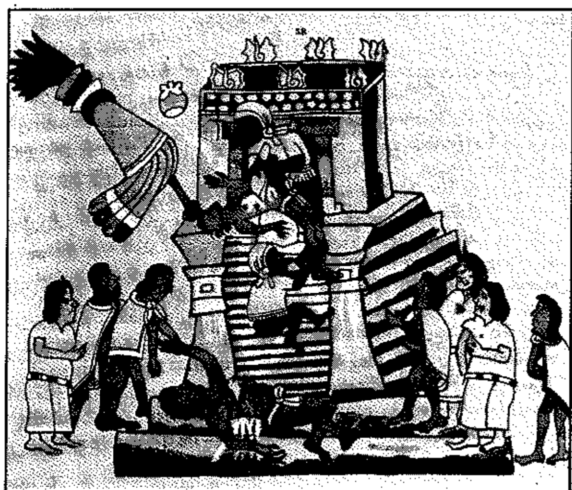
This truth, which stems from faith, is rarely understood by the world. How many times do those suffering from age or disease notice with bitterness that the world around them regards them as useless people, reduced to being a mere burden for others We must react against this utilitarian and subtly inhuman mentality, by rediscovering ever anew the meaning and function of suffering. The believer should constantly reflect upon the value of sharing in Christ's sufferings in order to live and help others to live more intensely the *particular vocation* to be found in the condition of old age or illness.

F. Hernández Rerum medicarum Novae Hispaniae Roma, 1628.

3. Dear friends, in moments of darkness keep your gaze fixed on the Mother of the Redeemer when she accepted the prophetic words: "and a sword will pierce through your own soul also" (*Lk* 2:35). Remember that even Jesus' lips uttered the disconcerting question: "My God, my God, why have you forsaken me?" (*Mt* 27:46).

Scripture teaches us that the Father brought to completion in the humanity of Jesus the greatest perfection "through suffering" (*Heb* 2:10). It was "through what he suffered" (*Heb* 5:8-9) that Jesus attained a singularly profound experience of obedience.

It is true, unfortunately, that in this ascent towards sanctity through suffering it is also possible to fail and turn away. There are those who shut themselves up in pain and become indifferent to others; there are those who become bitter and fall into despair. Suffering, without the intelligent and courageous cooperation of the individual, does not automatically save from superficiality and selfishness. One has to fight. But in this task one is never alone, not even for an instant. Standing beside us is the Father, who holds our hand and generously bestows on us his Holy Spirit, to make us grow in the knowledge that we are his children. Precisely through this experience of our frailty we are led to discover the loving presence of God and to pour out our pain to the one who alone can give us true relief. Suffering thus becomes a school of real, insistent, and trusting prayer.



Extracción ritual del corazón

4. Brothers and sisters, when after a day marked with discomfort and pain the evening comes, think of the fact that Jesus is at your side, looking into your face and telling you of his gratitude, for you have persevered with him in suffering for the salvation of the world. What joy it will be, one day, to hear the voice of the Risen Saviour: "You are those who have continued with me in my trials; and, I assign to you... a kingdom" (*Lk* 22:28-29)! Then it will really be possible to say: "And behold, some are last who will be first" (*Lk* 13:30)! When you reach his glorious presence, many together with him will greet you with joyful gratitude, because in their struggles and temptations you have helped them, gaining for them the strength not to despair and not to fail on the demanding path of fidelity to Christ! Then you will be able to understand fully the words of Paul: "I consider that the sufferings of this present time are not worth comparing with the glory that is to be revealed to us" (*Rm* 8:18)!

So have faith! No one is abandoned to his or her own weakness: Jesus Christ, who suffered for us, is beside you, supports you in your weariness and asks you to trust him. "Take my yoke upon you, and learn from me, for I am gentle and lowly in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light" (*Mt* 11:29-30).

5. Dear friends, the Church, too, is beside you with her charitable works. At the Council she restated her wish to be one, through the commitment of her members, "with people of every condition, but especially with the poor and the afflicted. On their behalf she gladly spends herself" (*Ad Gentes*, no. 12). In fact, during recent years, the Church has turned ever more decisively towards the poor, aware that in this "preferential option" for them, made up of generous solidarity and practical help, she puts into effect the commandment of love.

As I said in my Apostolic Letter *Salvifici Doloris*, Christ's words at the last judge-

ment "show how essential it is, for the eternal life of every individual, to 'stop,' as the Good Samaritan did at the suffering of one's neighbour, to have 'compassion' for that suffering and to give some help. In the messianic programme of Christ, which is at the same time *the programme of the Kingdom of God*, suffering is present in the world in order to release love, in order to give birth to works of love towards one's neighbour in order to transform the whole of human civilization into a 'civilization of love' " (30)

Dear friends, I entrust the commitment of each of you to the intercession of Saint Elizabeth, whom the whole Church knows and reveres for the marvellous examples of active charity towards people in difficulty, and of patient trust amid the grave sufferings which marked her own life, too. In proposing her as a model for everyone's life, I willingly impart to you and to those dear to you my blessing, as a pledge of the grace and comfort which flow from the life-giving presence of the Risen Jesus.

Diagnóstico de la enfermedad. Códice Tudela

Our Lady of Sorrows Speaks to Us of the Meaning of Suffering in the Plan of Redemption

John Paul II so affirmed before the recitation of the "Angelus Domini" on Sunday, September 15 1991 with the faithful gathered in the Courtyard of the Apostolic Palace of Castel Gandolfo.

1. "Stabat Mater dolorosa...."

The Mother of Sorrows was standing, weeping near the Cross from which her Son hung.

Today, September 15th, in the liturgical calendar is the memorial of the sorrows of the Blessed Virgin Mary. It is preceded by the feast of the Exaltation of the Holy Cross, which we celebrated yesterday.

What a perturbing mystery the Cross is! After having long meditated on it, St. Paul wrote the following to the Christians of Galatia: "As for me, I have no other boast except the cross of our Lord Jesus Christ, through which the world has been crucified for me, and I for the world" (*Ga* 6:14)

The Most Blessed Virgin could also have repeated—and with all the more reason—these same words. In contemplating on Calvary her dying Son, She had in fact understood that the "boast" of her divine maternity at that moment was reaching its culmination by participating directly in the work of Redemption. She had also understood that now human suffering, adopted by her crucified Son, was acquiring inestimable value.

2. Today, then, Our Lady of Sorrows, standing beside the Cross, with the silent eloquence of her example speaks to us of the meaning of suffering in the divine plan of Redemption.

She was the first to know and wish to participate in the salvific mystery, "associating herself in a maternal spirit with the sacrifice of Christ, lovingly consenting to the immolation of the victim engendered by Her" (*Lumen Gentium*, 58). Intimately enriched by this ineffable experience, She draws near to those suffering, takes them by the hand, and invites them to go up to Calvary with Her and pause before the Crucified One.

In that tortured body is the only convincing *reply* to the questions urgently rising from the heart. And with the reply there is also the strength necessary to take up one's place in that struggle, which—as I wrote in the Apostolic Letter *Salvifici Doloris*—pits the forces of good against those of evil (cf. no. 27). And I added, "Those who take part in the sufferings of Christ conserve in their sufferings a very special *Particle of the infinite treasure* of the Redemption of the world and can share this treasure with others" (*ibid.*).

3. Let us ask Our Lady of Sorrows to nourish in us firmness in faith and ardor in charity so as to be able to bear our daily cross with courage (cf. *Lk* 9:23) and thus participate effectively in the work of Redemption.

"Fac ut ardeat cor meum ..." "Make my heart burn in loving the Christ God in order to be pleasing to Him!" Amen!

Infirmity: Experience of Gospel Poverty

On Tuesday, February 11, 1992, the feast of Our Lady of Lourdes, the Pope celebrated Mass in St. Peter's Basilica in the late afternoon. Participating in the Mass were many health professionals and chaplains who have accompanied the sick on pilgrimage to the shrine of Lourdes and many of the infirm who have been there or are too weak to make the pilgrimage. During the Mass, which concluded with the singing of the Lourdes Hymn in the darkened, candle-lit Basilica, the Pope preached the homily in Italian as follows.

1. "As a mother comforts her child, so will I comfort you" (*Is* 66:13).

With this message today, the feast of Our Lady of Lourdes, the Word of God calls us together and encourages us.

In it we see the proclamation and promise that the Lord alone is our consolation. He obtains for us that liberation which so deeply marked the waiting of the chosen people. Today we are called to recognize and proclaim that in Christ the Redeemer every promise is fulfilled and the consolation which was foretold has become a reality.

I will comfort you: I, your God, will be your joy, your comfort and your rejoicing! I will make you rise from every evil, from sin and suffering of body and spirit. I will free you from that inner sadness which afflicts you because you have been separated from your God. I will console you with my mercy, purifying you from every fault and I will make grace, the divine life which springs up to eternal life (cf. *Jn* 4:14) flow towards you "like a river..., like an overflowing torrent" (*Is* 66:12).

All this will give you support, especially when the cross, which is present in the history of each person, knocks on the door of your life. Seen in the light of the cross, suffering bathed in the Redeemer's royal blood (cf. Hymn *Vexilla Regis*), is a fountain of salvation for every Christian.

2. The feast of Our Lady of Lourdes, therefore, returns as an event of grace, the feast which thousands of pilgrims, healthy and infirm alike, are celebrating together with us today, recalling the wonders which God, through her intercession, has worked in the grotto of Massabielle. At Lourdes, too, God reveals his love, fulfilling anew in our day the promise of consolation through the motherly tenderness of Mary

and the humble witness of St. Bernadette, who received the message. God consoles us, his people, when he has us reflect on the mystery of his Son, born of the Immaculate Virgin, the one who is *full of grace*.

Today our eyes contemplate in Mary the living image of the holiness desired by God, who calls us in Christ to be *holy and blameless* in his sight (cf. *Eph* 1:4). He, the Almighty, who did *great things* in Mary, consoles us, giving us in the Virgin a sure sign of hope. All the riches and graces which he has reserved for the human person and his or her destiny are found in Mary; in her is revealed the mercy which he has shown from generation to generation.

In Mary Immaculate human dignity is refound, the dignity of the person into whom God has breathed the breath of his Spirit. In her, Virgin and Mother, the victory of good over evil is revealed to us, as are the beauty of consecrated virginal love, the value and sanctifying strength of marital love, the living image of God's love. In Mary Immaculate we also see the mission of all women who, "by looking to Mary, find in her the secret of living their femininity with dignity and of achieving their true advancement" (*Redemptoris Mater*, no. 46). She is the admirable model for the young generations who, amazed at seeing so many expressions of material progress end up by harming people, are seeking *in the Gospel* the ideals which must inspire modern society.

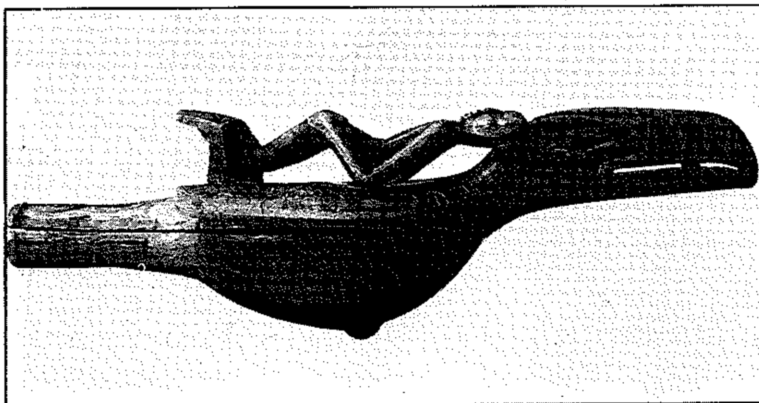
3. *"He has... lifted up the lowly. The hungry he has filled with good things.... He has helped Israel his servant"* (*Lk* 1:52, 53, 54).

These words from the "Magnificat" map out a plan and journey of faith. In that spirit this year's theme accompanies the pilgrims to Lourdes, inspired by the words of the Virgin: "Lourdes is the voice of the poor."

According to the Gospel, the sick person is a poor person, and all those who serve the suffering seek to understand its mystery in the light of the first Beatitude which Christ preached in the Sermon on the Mount.

Those who suffer are the image of Gospel poverty: a poverty which, enlightened by Christ's cross and suffering, is transformed into wealth and gift. In fact, it is precisely in the extreme "poverty" of Calvary that Jesus revealed himself as the Father's *"Servant"* and the *Redeemer-Servant* of every person. Suffering, etched in the body and spirit of every person, makes us understand the value and merit of those who are undergoing a difficult trial. The Church, born of the mystery of Christ's passion, is aware that the first way to meet man is that of suffering; in fact, in their earthly pilgrimage, all people come up against the reality of suffering in one way or another. At the side of the person who suffers, and proclaiming the blessedness of the poor in spirit, the Church passes on the consolation that comes from God.

That *consolation* is the heart of the message and the basis of hope. With Mary the Church believes in the fulfilment of the Lord's word and while she proclaims the blessedness of the poor, at the same time she proclaims the blessedness of faith: "Blessed is [she] who believed that what



Sonajero médico tlingit.

was spoken to [her] by the Lord would be fulfilled" (*Lk* 1:45).

4. "Blessed is she who has believed," and blessed, therefore, are all those who, *guided by the same faith,* work so that the promises of divine consolation will be fulfilled in the hearts of their suffering brothers and sisters.

With these thoughts in my heart, I greet all of you present here. I particularly greet *those of you who are sick* and are able to join your sufferings to those of the Redeemer on the Cross.

I greet Cardinal Vicar Camillo Ruini, to whom I convey all of my solidarity and esteem, and Auxiliary Bishop Luca Brandolini, responsible for the healthcare ministry in the Diocese of Rome.

I also express a thought for the members and consultors of the Pontifical Council for Pastoral Assistance to Health Care Workers, who are holding their plenary meetings during these days.

I am thinking also of all the members of UNITALSI, the Opera Romana Pellegrinaggi, and the associations which accompany and assist pilgrims going to Lourdes. I express to everyone my gratitude and my wish that your spirit of dedication in serving your brothers and sisters in need of help will always grow.

I also greet the participants in the first theological-pastoral congress on pilgrimages. I express my deep gratitude for the gift of medical apparatus to be donated to a new psychological teaching center. I also thank the pastor and faithful of Jesus of Nazareth Parish in Rome's Verderocca section for all they are doing on behalf of families and individuals in difficult circumstances.

Last of all, I thank you for the gift of the statue of Our Lady of Lourdes which will be sent to the Marian shrine of Larissa, Lebanon. I invite everyone to pray fervently for peace in that beloved, sorely-tried land and in all areas in which have been afflicted by fratricidal wars.

5. *"Blessed are you, Mary, among women"*! Accompanied by Elizabeth's words, we also want to raise a song of praise to the Virgin:

"*Blessed* are you among women and blessed is the fruit of your womb."

Blessed are you, O Mary, model of our faith and living image of our journey towards Christ.

Blessed are you, Virgin Mary, model of charity and motherly love for all who seek consolation.

Blessed are you, who brought forth for us the fountain of life.

Blessed are you because you have associated each of us with the redemptive suffering of Christ crucified and have called us to serve those who suffer.

Blessed are you because you go before us on the way of the Gospel and invite us to do whatever he, your Son, tells us to do along the pathways of the world. Blessed are you because you teach us to love the poor, the lowly, and sinners as God loves them.

Blessed are you, Mother of the Lord, and blessed is the fruit of your womb, Jesus Christ our Lord.

Amen.

Pipa haida

Message to the Catholic Medical Associations of Latin America

A letter to His Eminence Fiorenzo Cardinal Angelini President of the Pontifical Council for Pastoral Assistance to Health Care Workers, dated July 6, 1992.

Your Eminence:

On the occasion of the Meeting of the Catholic Medical Associations assembled to constitute the Latin American Federation of these Associations, the Holy Father wishes to convey his cordial greeting to Cardinal Nicolás de Jesús López Rodríguez, Archbishop of Santo Domingo and President of the Latin American Bishops' Conference (CELAM), to the representatives of the national associations of Catholic physicians, and to the religious, academic, and civil authorities attending

It is certainly significant that the timely initiative of constituting the Latin American Federation of Catholic Medical Associations is being carried out in the framework of celebrations of the Fifth Centennial of the evangelization of America. In effect, among the "bright spots" of that evangelization the efforts by ecclesial communities in the New World to care for the weak and the sick, following the example of the Lord Jesus, the physician of souls and bodies, must be enumerated.

The evangelization which the Church is called to carry out in our time will be new in its ardor, its methods, and its expression if, as in the most glorious periods, it encounters one of its most outstanding objectives in concern for those suffering.

The new Federation is, then, worthy of praise; it arises to respond in a coordinated, convergent, and solidary manner to the multiple and complex problems posed today for medicine as science and as praxis. Especially in the countries of the Latin American continent, medicine must face grave and urgent tasks whose solution requires a clear conception of the human person and his dignity.

The Holy Father thus wishes and invites Catholic physicians to be a reference point for the defense and promotion of the primary value of human life from its conception to its natural close, through faithful adherence to the teachings and directives of the Magisterium of the Church in formulating the questions considered by bioethics. In fact, today more than ever those professing the Christian faith have the duty, especially in the field of medicine, to defend life against the alarming aggressions represented by contraception, sterilization, abortion, genetic manipulation, and euthanasia. It is necessary to promote a defense of life which is accompanied by vast and effective action in prevention, health education, and training of the younger generations of doctors.

Catholic physicians, both individually and through their associations, must feel their profession to be a mission and vocation capable of being translated into valiant, credible witness.

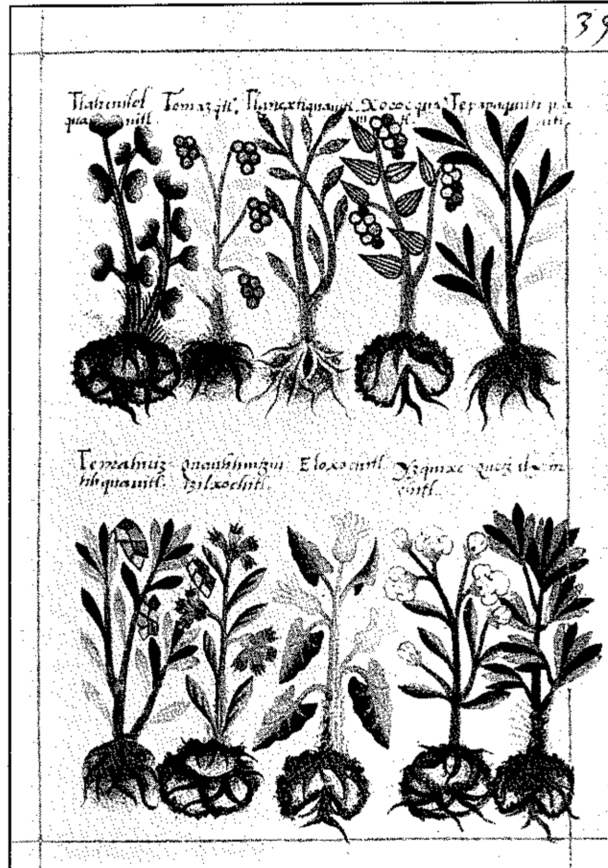
In order for the new evangelization to be a sign of hope as well, it is necessary for medicine, in all its modalities, to be nourished by the culture of life, which is an indispensable condition for building the civilization of love

The Holy Father invokes the Most Blessed Virgin Mary, radiant Star of the first evangelization of America, that She may accompany and bless the work of the new Federation of Catholic Medical Associations and expresses his best wishes in the face of its urgent tasks, while cordially imparting the Apostolic Blessing to its members.

ANGELO Cardinal SODANO
Secretary of State of His Holiness

Sacrificios y penitencias de los enfermos

Topics



Plantas medicinales para la fatiga de los gobernantes Códice Badiano

Humane Medicine as an Alternative to Euthanasia

The Traditional Understanding of Health, Illness, and Care in Nigeria

Medicine and the Conquistadores

Humane Medicine: An Alternative to Euthanasia

Once abortion has been successfully legalized (in Spain it has been under three aspects, and the fight continues to broaden them, though pro-life movements are also forcefully expanding), the legalization of euthanasia begins to be proposed

Some countries which were pioneers in depenalizing abortion are in the forefront in the practice of euthanasia as well.[1] The case of Holland is very significant, where, although it is not legalized, the most reliable studies provide alarming figures on this practice which show that society is favorable. Ten of the twelve political parties are in favor of euthanasia and include it in their platforms

According to a report by R. Feningsen,[2] family doctors perform active euthanasia about 5,000 times a year, and another 5,000 cases arise at hospitals. Other statistics provide higher figures, reaching 20,000 cases of active euthanasia in this little country

It proves symptomatic, to judge by the testimony of press agencies, that one of the best sellers in the United States in the first half of 1991 was the euthanasia manual *Final Exit* by Derek Humphrey, head of America's pro-euthanasia Hemlock Society.

In Spain Socialist Senator Cesáreo Rodríguez Aguilera (member of Spain's Association for the Right to Death with Dignity), announced to the press in 1988 that he was drafting a proposal for a euthanasia law. The key elements in his proposal were:

a) recognition of the "living will" as a legally valid document for third parties and

b) depenalizing (under certain conditions) the assistance given to those not wishing to prolong their lives in "unworthy" circumstances. It was specifically proposed to suppress Article 409 of the Penal Code

Although the party in power (Socialist Workers) countered that initiative by pointing out that euthanasia was not among the legislative proposals on its agenda, it is certain that the way is being paved for it by newspaper articles and skillfully directed televised debates—in short, by sowing confusion

What Euthanasia Is and Is Not

The first thing to be specified is terminology, for the very term "euthanasia" has become an ambiguous concept, when not equivocal.[3] The word is frequently used for situations having nothing to do with the real practice of euthanasia.

The Congregation for the Doctrine of the Faith, in a 1980 Declaration, gave a general definition: "an action or omission which, by its nature, or in an intentional manner, produces death for the purpose of eliminating all pain" (no. 2). For the sake of clarification adjectives are added—e.g., terminal, palliative, or suicidal euthanasia. At present the terms active and passive euthanasia are often used, though they are not very appropriate. For the patient everything is passive as regards the treatment he does or does not receive, whereas for the doctor everything is active, including the decision not to apply further treatment. With this qualification, since it is ordinarily employed, we may specify the following.

Active euthanasia is the practice of a positive medical action whereby a patient's life is ended, whether by administering lethal drugs (cyanide, overdose of morphine or sedatives, etc.) or by omitting means (food, medication, etc.) needed to keep the patient alive, for whatever reason (mercy, compassion, the right to die, etc.)

From time to time the mass media convey chilling examples.[4] In these instances we might speak of *direct* active euthanasia.

There is often mention of *indirect active* euthanasia as well, when drugs are administered which may accelerate a patient's death but which are used to alleviate his pain. Though there is *active* intervention by the physician in this case, the term "euthanasia" should not be applied because, even though life is shortened, drugs are not used with this intention. This procedure is ethically licit, even if it entails, as we said, the acceleration of death

Passive euthanasia is the non-application of therapy to prolong the patient's life. But this proves equally confusing since such an omission of therapy may be blameworthy (when the means deemed ordinary and proportionate to keep someone alive are not used), or, in the case of what is commonly understood to be passive euthanasia,[5] it may be a reasonable decision not to employ disproportionate means to maintain the life of an terminal patient, frequently in a artificial manner. The phrase "passive euthanasia" should be avoided, as it leads to error (in fact, the Declaration of the Congregation for the Doctrine of the Faith of 1980 does not use it). Of course, the defenders of euthanasia may be seeking just that—they tend to "slip in" those cases which do not constitute the reality of euthanasia so as to push through others which do represent flagrant instances —that is, they want to pass euthanasia off as licit by deliberately confusing it with other perfectly admissible practices from the standpoint of medical deontology.

In 1981 the Pontifical Council *Cor Unum* published a document[6] pointing out that the term euthanasia should not be applied in the following cases:

— to indicate terminal care destined to make the final phase of illness more bearable;

— to refer to an intervention destined to alleviate a patient's pain, even if it entails the risk of shortening life;

— to designate the decision to renounce certain medical interventions which do not seem appropriate for the patient's situation (foregoing extraordinary means).

The term euthanasia should, then, be reserved for those acts which simply aim to put an end to the patient's life.

The Most Frequent Arguments

To justify euthanasia there is recourse to a number of arguments which we can summarize as follows:

a) Persistent, uncontrollable, and atrocious pain. If pain cannot be suppressed, especially when death is inevitable, it is better to put an end to life, they assert. Current society, hedonistic and fuzzy in thought, regards the vision of pain, illness, deformity, and death as unacceptable.

b) Lives lacking value. There are situations wherein a person's life lacks all sense and value; as a result, the right and even the duty of not having that useless life burden all the rest of the collectivity are claimed. The associations in favor of euthanasia resort to the concept of *quality of life.* It is not sufficient to attend to the biological dimension of a life, but a set of interpersonal and relational values accompanying it must be considered. A life lacking that quality is not worth living, they assert.

c) Lives which are an unbearable burden for the family, society, or the State. The incurably sick, hopeless old people, the thoroughly disabled—euthanasia for deficient neonates, AIDS victims, and others fits into this category.

d) The right to dispose of one's own life. Some feel life is the exclusive patrimony of each individual and that he can dispose of it as he wishes. The importance of the living will is stressed: when a subject, with lucidity and responsibility, formulates his own decision in relation to euthanasia, he should be taken into account. A specific anthropology of a radically existentialist variety which is hardly reconcilable with Catholic faith underlies this view.

I think these are the most widespread arguments in public opinion which must be responded to.

Obviously, the deeper formulations in favor of euthanasia (*absolute freedom* to decide on life or death, the *uselessness of a life* submerged in atrocious, uncontrollable pain, etc.) clash head-on with Christian doctrine, which teaches that:

a) man is not the absolute owner of his life;

b) life is worth more than the absence of pain: there is no useless life, no matter how wounded by suffering;

c) the dignity of the human person excludes the value of life being measured by criteria of quality;

d) pain, in a transcendent vision of life, has meaning, even if we cannot manage to understand it (cf. the Apostolic Letter *Salvifici Doloris* by John Paul II).

Each of these topics lends itself, then, to deeper study.

The introduction to the document of the Spanish Bishops' Conference of March 25, 1991, *Abortion: 100 Questions and Answers*, announces a future text devoted to euthanasia in which we assume these subjects, among others, will be dealt with.

We wish to pause here on a concrete question which, when properly focused, can demolish many pro-euthanasia arguments. The question is *How are terminal patients to be attended?*

This is a topic of serious concern, for there have been and may be deficiencies. Let it suffice to recall the abundant bibliography in existence.[7]

Those supporting euthanasia find arguments in their favor here, for we are all afraid of death with pain and/or "therapeutic obstinacy."

Accordingly, if alternatives are found capable of humanizing the process of death, we take arguments away from euthanasia backers. And the alternatives exist. We shall refer to them.

Alternatives to Euthanasia

1) *Good medicine controls horrible pain.* Pain should not be a reason to request euthanasia because it can at present be combatted successfully. With the progress of algology (the science treating and combatting human pain), some have come to affirm that euthanasia constitutes an "outmoded" practice: it has been asserted with reason that if they cannot take away your pain, you should not ask for euthanasia, but change doctors.

Pain Units, hospital departments focusing on the scientific treatment of pain, are well known. Others think these units are not even necessary if specialists (oncologists, above all) are capable of adequately handling the analgesic arsenal of *palliative care.*[8] In reality, the two concepts are interlaced. There is a European Association for Palliative Medicine, created in 1988, which draws inspiration from the health units propagated by the "hospice movement" in England and the United States. In 1990 it held its first Congress in Paris. Its objective is "to offer the dying a third possibility between therapeutic obstinacy and euthanasia: to die in a dignified and natural manner." [9] In Spain we are familiar with the Catalonian-Balearic Society for Palliative Care,[10] and there are many hospitals which now have Pain Units, in the awareness that suppressing all avoidable pain should become an objective of national health plans.

Everything seems to indicate that Palliative Medicine, now in its early phases, will before long become a high-quality specialty in scientific terms and that pain control in terminal patients, the leading concern for doctors and patients, will—and is already starting to—be a reality.

Among other things, this means pulling apart a series of axioms which are assumed to be true and are not. For instance, the following affirmations, although containing some truth, are not thoroughly truthful: [11]

— All cancers are painful (a third are not).

— Pains increase with the progress of cancer.

— Pains become so great that they cannot be alleviated.

— If the patient regularly takes sedatives, he will fall into addiction.

— Sedatives should be administered only when there is pain.

— Morphine is used only when the end is near.

— Pain control is always associated with a decrease in consciousness.

2. *There are also medical facilities and institutions* where personal assistance is given to the terminal patient so he will accept his destiny and die in peace. This is what happens or should happen in hospitals with a Christian inspiration. In my ten years as a chaplain at the University Clinic of Navarra, known for both its high scientific standards and the human quality of its care, I am familiar with only one case where a person requested euthanasia for his wife, who had numerous and intense pains.

It sufficed simply to intensify palliative care by resorting to morphine to eliminate that desire. But we refer here concretely to the figure of the hospices[12] of the Anglo-Saxon countries, whose philosophy is spreading to other nations. In the United Kingdom there are over 170 home care services.[13] In the USA, there were 1400 in 1984.

It is quite interesting to hear what Cecily Saunders, founder of St. Christopher's Hospice and a pioneer in this movement, has to say; she is convinced that "life has meaning in any situation" and there must thus be attention to "the quality of life of the people with incurable illnesses." In statements offered to The *Sunday Times Magazine* she explained her lifestyle and the objectives of her hospital:

"I get up at 7:15. Sometimes I try to pray in bed, but am not always successful. I punctually do spiritual reading; a book of devotions or, at times, something more theological.

When you work with people facing death, you have to make a mental effort and find the meaning of all of this.

I go to work and arrive at 8:50 at the hospital. At St. Christopher's we deal with everything needed for the lives of people with incurable illnesses. People hate the word 'incurable'—it sounds so dark and depressing. However, St. Christopher's is a very cheerful place, and the feeling is of life, not just death.

I founded the hospital in 1967. Slightly after the war, when I was a social worker, I used to visit a Polish Jew who had come from the Warsaw ghetto. When he died, at age forty, he left me 500 pounds sterling and told me, 'It will be a window in your home.' It took me nineteen years to build the rest of the house, starting from that window.

We have a prayer period at nine, for ten minutes. It is very important, and we never fail to do so. This is a Christian foundation, as well as a medical one. We firmly believe that in any situation life has meaning. When one reaches this state, so many superficial things worrying people have crumbled, and now they face reality, but it's an occasion for the family to be reunited in a different way. The hospital is aimed at families. A very important part of our objective is for the patient and the family to form a unity. We want to help the group as a whole, for later it will be the family that will go on living."[14]

In relation to this subject, in Spain there have been proposals to devote some private hospitals (above all, belonging to religious institutions) to this need. Something has already been done in regard to AIDS victims.

3. Home care for terminal patients has been initiated in recent years. This task is clearly situated among those of Christian charity, provided it is carried out with professionalness. Here Church institutions (parishes, etc.) have a fertile field.

The initiative of the late Professor Romanini, of Rome's Polyclinic, is well known.[15] In Navarra the Provincial Council of the Spanish Cancer Association has begun a similar service, for which it has many volunteers available.[16] Many initiatives of this kind exist.

4) In the final analysis, helping people to die with *dignity is involved*. But what does a worthy death really mean?

For there is a lot of cheap literature and sophistry. Let it be recalled that in the fact of dying there is no dignity, since death is itself unpleasant.[17] Dignity derives from the way the sick person faces up to it, from the stature of the soul of the one confronting death and not from the absence of external complications (medication, real or assumed therapeutic obstinacy, etc.), which are usually not lacking.

We shall point out some criteria on what might be regarded as a worthy death.

— To know that one is going to die—hence the right to adequate information and the role played by the doctor in being prudently truthful.[18]

— To share the decision on the medical treatment to be followed: the patient (or the family) must be informed and have the capacity to decide to accept or suspend a treatment, and so on. "Medical care must be a process shared by two experts, the professional and the patient, who knows what he wants and desires."[19]

— To seek to maintain as far as possible certain activities and family relationships. Dignified death requires those close to the patient to treat the human being until the end as what he is: a creature in the image and likeness of God.

We feel that the frequent claiming of the right to die with dignity simply amounts to devoting maximum attention to what is today regarded as humanity in medicine.[20] This humanitarian outlook, present in every process of illness, should be maintained to the utmost when the terminal phase arrives: "the doctor must then abandon the idea of curing and devote himself to the task—very demanding in terms of science, competence, and humanity—consisting of relieving and consoling."[21] When people act in this way, there is no place for a request for euthanasia by some terminal patients. There is a paragraph in the Declaration on Euthanasia by the Congregation for the Doctrine of the Faith which I think is supremely important: "The requests by very seriously ill patients who sometimes ask for death should not be understood as the expression of a real desire for euthanasia; they are, in fact, nearly always anguished requests for care and affection. In addition to medical care, what the patient needs is love and human and supernatural warmth, with which all who are close to him, parents and children, doctors and nurses, should surround him" (Part II).

Teaching of the Spanish Bishops

The Spanish Bishops have shown a fine sensitivity to this subject.

The Bishops' Commission for the Doctrine of the Faith published a note on April 15, 1986 concerning euthanasia. The document ties in with the Declaration on Euthanasia by the Congregation for the Doctrine of the Faith (May 5, 1980) and alludes to the dehumanization of medicine at large healthcare institutions and to the difficulties encountered by health professionals, patients' families, and pastoral workers themselves when it comes to accompanying the terminal patient humanly and spiritually. The importance of having some specifically Christian presuppositions to deal with the subject is also stressed.

Later, in September 1989, the Spanish Bishops' Conference made public a report on *Accompanying the Dying and the Legalization of Euthanasia* (cf. *Ecclesia* 1989, p. 1438 ff.) Particularly important is the drafting of a living will of Christian inspiration, which has been accepted very positively and may serve as a means of evangelization to promote a good death among Christians. It also contains a series of *concrete objectives and actions* which ought to be carefully observed, for valuable points —some are already being implemented—are included. We may cite the following

— Catechesis on death, pain, suffering, etc.

— Revitalizing the pastoral care of the sick—both terminal and nonterminal—in parishes.

— Recovering Anointing as the Sacrament of the Sick and Viaticum as the Eucharist of the passage from this life

— Promoting the creation of centers providing integral help to the terminally ill.

— Supporting and fostering volunteers in the care of the sick.

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[1] This was foreseeable and was pointed out by many authors. The Pope also recalled it on his trip to Poland in 1991: "The increasingly widespread formation, even among naturally honest people, of a permissive mentality on abortion also leads inexorably to the acceptance of another direct suppression of life for both the elderly and invalids and the physically and psychically handicapped—that is, euthanasia" (Address to the Polish Bishops' Conference, June 19, 1991)

[2] Cf *Un caso de eutanasia. Informe sobre la situación en Holanda*, in *Revista Atlántida*, 5 (1991), 14-28

[3] G. HIGUERA, *¿Eutanasia?* in *Sillar*, 17 (1985), 59-71.

[4] J. GRAU, *Las enfermeras de la muerte* (Barcelona, 1989).

[5] Cardinal FIORENZO ANGELINI, *Quel soffio sulla creta* (Rome, 1990), 348

[6] PONTIFICAL COUNCIL COR UNUM, *Algunas cuestiones éticas relativas a los enfermos graves y a los moribundos*, in "Documenti di deontologia ed etica medica" (Milan: Paoline, 1985), 91-110.

[7] CH. JOMAINE, *Morir en la ternura Vivir el último instante* (Madrid: Paulinas, 1988). I. DELISLE-LAPIERRE, *Vivir el morir* (Madrid: Paulinas, 1990). A. BRUGAROLAS, *Síndrome terminal de enfermedad. Criterios y actitudes*,in *Revista de Medicina de la Universidad de Navarra*. April-June 1988, 11-118. J. GAFO, *La eutanasia. El derecho a la muerte humana* (Madrid: Ed Temas de Hoy, 1989) F. MONGE, *¿Eutanasia?* (Madrid: Ed Palabra, 1989). Second International Conference of the Pontifical Council for Pastoral Assistance to Health Care Workers, devoted to "The Humanization of Medicine," in *Dolentium Hominum*, 7 (1988) G. HERRANZ, *El respeto médico a la vida terminal*, in *Atlántida*, 5 (1991), 26-34. B POLLARD, *Eutanasia* (Madrid: Rialp, 1991) P.L. MARCHESI, S. SPINSANTI, and A. SPINELLI, *Por un hospital más humano* (Madrid: Paulinas, 1986)

[8] CECILY SAUNDERS (foundress of St Christopher's Hospice), *Hospice and Palliative Care. An Interdisciplinary Approach* (London, 1990) R. LAMERTON, *Care of the Dying* (London: Penguin Books, 1980). In Spain the first palliative care unit was created at Marqués de Valdecilla Hospital in Santander in 1984; the second, in Lérida (1987).

[9] Cf *Labor Hospitalaria*, 220 (1991), 96-119.

[10] Cf. *Ibid.*, 107 (1990), 107-109.

[11] Cf. B. POLLARD, *op cit*, 86-88

[12] Cf. PORTA and SALES, *About hospice, un nuevo concepto de la atención de pacientes con enfermedad terminal*, in *Labor Hospitalaria*, 295 (1987), 155-161. J. OBIS, F JORDAN, M. CAMPOS, *Una visita al Saint Joseph Hospice de Londres*, in *Labor Hospitalaria*, 207 (1988), 32-35 J GAFO, *op. cit*, 129 ff. F MONGE, *¿Eutanasia?* 129 ff S. STODDARD, *The Hospice Movement. A Better Way of Caring for the Dying* (London: Jonathan Cape, 1979).

[13] Cf. SCARCELLA-CALAMO, in *Medicina e Morale*, Rome, 3-4 (1988), 411-414

[14] Servicio Aceprensa, 138/84 Cf. M C. SAUNDERS, *Cuidados de la enfermedad maligna terminal* (Barcelona: Salvat, 1980).

[15] Cf ATTILIO ROMANINI, in *Medicina e Morale*, 3-4 (1988), 455-464.

[16] This initiative, in the program of attention to patients and their families, functions as follows: there is an office where a group of retired people on different shifts answer phone calls requesting help. They pass them on to a "Quick Action Group" (sixteen advanced medical students), which, after visiting the patient's home and getting a grip on the situation, turns to one of dozens of volunteers (mostly students) to obtain the service requested (accompanying the patient during the day or at night, etc.).

[17] Cf. L. R. KASS, in *Human Life Review*, New York, XVI (1990).

[18] M A. MONGE, *La verdad ante el enfermo*, in *Etica salud enfermedad* (Madrid: Palabra, 1991), 215-229

[19] B POLLARD, *Eutanasia* (Madrid: Rialp, 1991), 83.

[20] Cf. the International Conference cited in note 7

[21] G. HERRANZ, *op. cit.*, 34.

Médicas incas

The Traditional Understanding of Health, Sickness, and Care in Nigeria

Introduction

Health has been rightly shown by the Catholic Bishops of the United States of America as something that profoundly touches the life of every human being. Elaborating on this, they pointed out that each person's ability to live a fully human life and to reflect the unique dignity that belongs to him is deeply affected by health.[1] Accordingly, there is a universal concern about regular maintenance of good health and a proper control of its enemy, sickness. Hence St. Paul remarked that "a man never hates his own body, but he feeds it and looks after it" (*Eph* 5:29).

This universal concern for regular good health has never eluded the people that inhabit an African country known as Nigeria. One observes, however, that the striving for good health by these people has some peculiar elements which are fundamentally connected with the way they traditionally understand health, sickness and health care. This article is aimed, therefore, at reviewing the manner in which Nigerians traditionally understand health, sickness, and health care. The word "traditional" is used here to show that the article is mainly concerned with a Nigerian understanding that is unaffected by any outside influence and mentality, an understanding that reflects the original way of thinking and living in Nigerian. Though Nigeria is a very large country, with about 394 ethnolinguistic groups,[2] the whole country is being covered by the article as a unit because of the fact that "whatever the area, traditional health care systems have basic characteristics which are comon to them."[3]

I. The Concept of Health

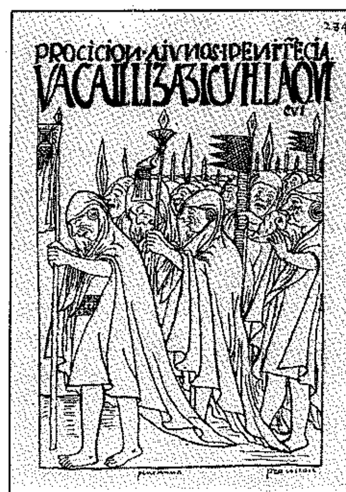
1. *Some Traditional Expressions for the Word "Health"*

The concept expressed in English by the term "health" is expressed in the various languages of Nigeria in different ways. In general, however, the various words and phrases used in expressing this denote a good state of body and strength. In Igbo language, for example, the most regularly used phrases for health include *aru-ike* (strong body); *aru-idi-mma* (goodness of body); *aru-izu-oke* (wholeness of body). And the phrase "being healthy" is expressed with such phrases as *idi-ike* (being strong); *iji-ike* (having strength); and *idi-ndu* (being lively/active). In Hausa language expressions for health include *lafia-n'jiki* (peacefulness of body) and *karfi-n'jiki* (strength of body).[4] In Yoruba the expressions for health include *didá ara* (soundness of body) and "healthy" is often expressed by the word *tagun* (strong, vigorous).[5]

2. *Health as Multidimensional*

Though Nigerians very often express the concept of health in terms of body-state and physical strength, they do not use the physical state of man as the only parameter for measuring health. For them health goes beyond the physical condition of man. Their understanding of health is connected with their understanding of man, an understanding which they share with the other traditional societies of the whole of Africa.

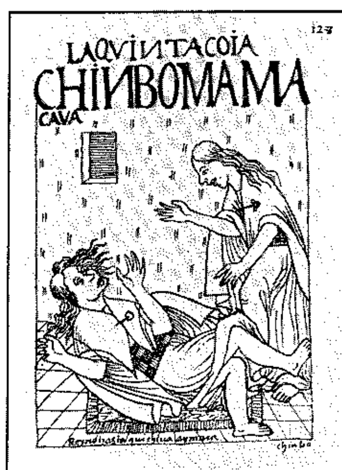
For the African, man is not just a physical being, but a being who has also a spiritual aspect. Man is not a being in isolation but one who is by nature relational. He is a being meant to be in constant relationship with his creator, with the whole spiritual world, with his fellow men on earth and with the entire created universe.[6] In short, for the African health involves not only physical exuberance but also harmonious integration of an individual with the entire universe, both spiritual and material. Accordingly, Kofi Appiah-Kubi, writing on how the Akans understand health, said: "To be healthy implies to be healthy in mind, body, and spirit. This calls for living in harmony with one's neighbours, the environment, and with oneself—physical, so-



Ritual inca para ahuyentar las enfermedades

cial, spiritual, natural and supernatural realities."[7]

Nigerians, like the rest of Africans, also traditionally see health as a multidimensional reality They do not measure health by only the degree of a person's physical strength and exuberance. They always take into consideration the degree of the individual's internal peace and serenity, his capacity to exercise self-control, his ability to relate well with other people, and the seriousness with which he handles his religious and social responsibilities[8]



Epilepsia de la Quinta Coya

II. The Concept of Sickness

A presentation of the way Nigerians traditionally understand sickness will not only help towards a better understanding of their method of health care but will also throw more light on how they understand health. They generally see sickness as an evil opposed to health, an evil that arises in various ways, and an evil that is multidimensional in character.

1. *Sickness As an Evil*

"Evil" as used here refers to something that is disagreeable and unfortunate; something that produces unhappiness or calamity[9] In Nigerian traditional society, sickness is generally seen as a great evil. This is very clearly shown by the various words and phrases used in expressing it The Hausas call it *Chiwo* or *Ciwo,* whose meanings include "something disheartening." And they describe the state of being sick as *da rashi-n'lafia,* which literally means "with lack of peace."[10] The Yorubas call sickness *arun* or *aron,* which among other things means "disorder" and "pest" And they call a sick person *alarun,* which means "an invalid." Furthermore, the words with which they describe the state of being sick include *lailagbara,* which has among its various meanings "powerless," "disabled," "impotent," and "invalid."[11] The Igbos call sickness *aru-onwunwu* (body-dying), *ikea-dighi* (strength-lacking), *aru-a-dighi* (body-lacking), *ejighi-ahu* (body-lacking). With these and other similar words and phrases the various ethnic groups of Nigeria express how destructive they consider sickness to be As a result of this, their general attitude to it is that of strong detestation.

They also express this detestation with various phrases and actions For instance, the Yorubas say, *Arun l'ota enia* (sickness is the enemy of man). The Isoko people say, *Enya th'owho rha* (sickness should bypass one). And G.T. Basden remarked on the Igbos that "at intervals, stipulated ceremonies are fulfilled and sacrifices offered for driving out sickness."[12] A similar practice is also reported on the Idoma people of the Northern section of the country[13] and on the Yorubas. According to J. Omosade Awolalu, the Yorubas perform this sacrifice with a "scapegoat" known as *Tele* over which the people would shout: "Take disease away! Take misfortune away! Take pestilence away!"[14]

2. *The Causes of Sickness*

In Nigerian traditional society it is hardly believed that a sickness can arise without an extraordinary intervening cause. The usual belief is that every form of sickness is caused by a direct action of some supernatural being or human being. They do, however, admit that sickness can arise also through other means. Here are some examples of the agencies to which sickness is generally attributed:

a) *Supernatural Agencies*

In Nigerian traditional society, sickness is most commonly attributed to the action of supernatural beings. These include evil spirits, ghosts of the dead, various gods, spirits and ancestors of each land, and some special group-spirits such as *ogbanje* or *abiku.*

Evil Spirits

Some sicknesses are believed to be caused by the action of evil

spirits who often take special delight in inflicting harm on people on earth. For example, Mucizz Goriawala has pointed out that the Hausas believe in black *iskookii* (spirits) "who are held to be evil and who live in the bush," and who are held to have a part in the causation of illness.[15] He also showed them to believe in *jinn*, which he described as "an invisible order of creation." He pointed out that some of these are evil and that "in relationship to human beings they are believed to be mostly harmful." He remarked that insanity is often attributed to these, and for this reason "the insane are believed to be under the spell of *jinn* or possessed by him."[16]

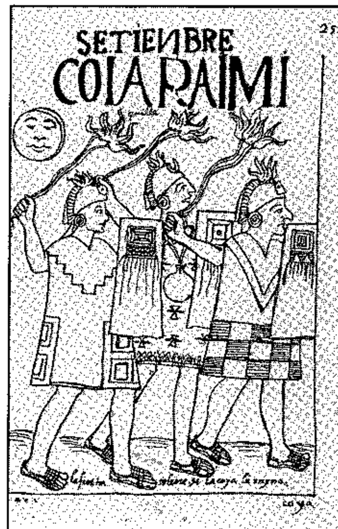
Similar remarks are made by D.R. Price-Williams on the Tivs, among whom he observed a frequent attribution of sickness to the action of "malevolent forces."[17] It has been shown also that the Yorubas have a "belief that a series of calamities may befall a man, not necessarily [because] he has wronged or neglected a divinity or an ancestral spirit but because the evil ones who use their nefarious powers to harm others plan evils against him."[18]

Among the Igbos, G.T. Basden remarked that "for the most part the natives do not attribute sickness to natural causes" but rather to "the spiteful attentions of an evil spirit or other agencies."[19] And, according to A.G. Leonard, this attribution of sickness to the action of evil spirits is so frequent among the whole people of Southern Nigeria that very often "the ordinary malarial fever, which is so common a feature in Delta life, is nothing but the active presence of an inimical spirit."[20]

Prominent among the evil spirits to whom Nigerians, especially those in the Southern part of the country, readily attribute sickness are the water spirits. Many Igbos, for instance, strongly believe that there is a special group of spirits who have their abode in oceans, seas, rivers, and streams. They are often called *Mamiwata* (Mammy Water or Mermaid) or *Mmuo Mmiri* (Water-Spirit). These are believed to cause sickness in various ways. Sometimes they could inflict on an individual "a strange unknown sickness"[21] out of mere sadism. Sometimes they inflict sickness on a person for refusing to grant consent to their request for his friendship or marriage with them. At other times they are believed to inflict sickness as punishment on one who entered into friendship, marriage, or other forms of partnership with them but failed to abide by the terms of agreement.[22]

The Ghosts of the Dead

Some sicknesses are often attributed to the action of ghosts of the dead who are believed to be roaming round the earth because of a non fulfilment of the funeral rites essential for their admittance into the land of the dead.



Ritual inca de Coya Raimi

Geoffrey Parrinder remarked on the whole people of West Africa that "sickness and misfortune are often believed to be due to some neglect in fulfilling the last rites with due care."[23] Accordingly, M.Y. Nabofa said of the Urhobo people, and implicitly of the whole of Nigeria: "All the elaborate funeral rites accorded the dead by the living members of the family are meant to demonstrate to the ancestors that [the dead relative] was a good person among them and as such should be accepted into their fold." He compared the funeral rites with passports and letters of recommendation, and pointed out that those against whom the gates of *Urhoro* (the gate separating the land of the living from the land of the dead) are barred become wandering spirits who go about as mischievous beings.[24]

In other words, Nigerians traditionally believe that when a person dies, befitting funeral ceremonies must be performed for him to enable him to have easy and quick access to the land of the dead. Failure to do this would make the soul of the departed one wander homeless. Thus he could return to make life very unpleasant for his relations on earth with various forms of afflictions which very often include sickness.

The Gods, Spirits, and Ancestors of Each Land

It is a common belief in the traditional society of Africa that the various individuals, families, and communities are in relationship with some gods, spirits, and ancestors who could help them lead a successful life on earth. Sometimes sickness is attributed to the action of these gods, spirits, and ancestors. It is believed that these could inflict sickness on an individual or a community as vindictive punishment for some infringement of the moral codes established by them or under their custodianship. Hence Robert Parsons remarked that in Africa "disease conditions are attributed to the breaking of tabus and are seen as automatic retribution operating naturally."[25]

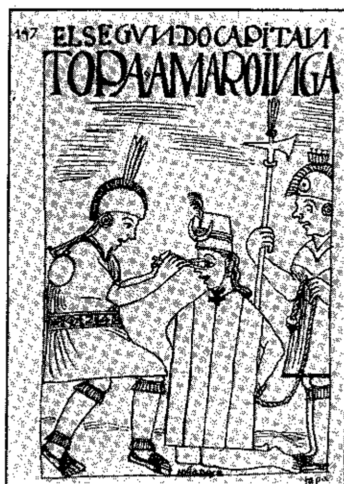
A practical illustration of this belief among Nigerians is shown by C.L. Temple in his report on the Angas of northern Nigeria. He remarked that these have a god called *Gwon*, who is essentially the god of justice. To him are referred all questions of right and wrong, and he would often punish an offender by making "his belly swell until it bursts."[26] Temple also made similar observations on other places.[27]

Among the Igbos, G.T. Basden observed a belief that ill-health often "springs from the activities of spirits who have, in some unknown way, been offended and who display their wrath by inflicting sickness."[28] In Annang there is a disease called

Adia Abasi characterized by the swelling of legs. According to Matthew Aquaowo, the people believe that anyone afflicted by this disease "has violated the morality or taboo of the society." [29]

The Abiku/Ogbanje Spirits

Some Nigerians often attribute the cause of sickness to the action of a special group of spirits believed to be responsible for a phenomenon known in Yoruba as *abiku* (born-to-die) [30] and in Igbo as *ogbanje* (life-repeater). *Abiku/Ogbanje* is a special form of reincanation peculiar to a group of people "believed to be capable of reincarnating into various 'life-journeys' which last for a very short time during each trip." [31] In a very succinct description of how it obtains among the Yorubas, Awolalu said: "The Yoruba believe that some children, especially girls, had entered into an unpleasant covenant with mischievous spirits before they were born; and prominent in their agreement is the vow to die (that is, to return to their 'companions') at a covenanted time, possibly as soon as they get to the world, or when they are about to be married or when they have got two children, or as soon as they have a male child." [32] This phenomenon has been shown also to occur among the Urhobo people, who are said to believe in "wandering *Irhi* (spirits) who enter some women's wombs only to be born and to die soon after." [33]



Enucleación ocular inca

The sickness caused by *Abiku/Ogbanje* spirits affects mainly the people who have a pact with them. It can, however, affect others also if it is an infectious disease.

Sickness can arise here in two different ways. In the first place, an *abiku/ogbanje* person can be regularly sick following a way of life he adopted to lead while on earth. According to Bertram Osuagwu, before an *ogbanje* person leaves the spirit world for the human world, he usually decides on a form of life to adopt while on earth. Very often one adopts a form of life by means of which one would torment and cause heart break to the parents and the entire members of the family in whose company one would spend the temporal life.[34]

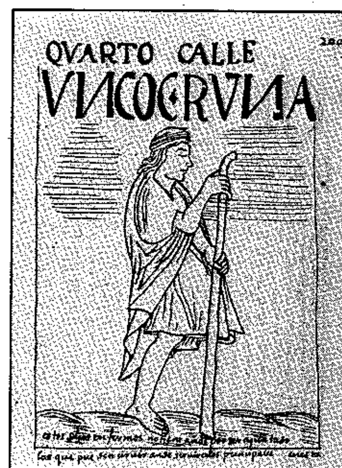
The second manner in which sickness can arise out of *ogbanje* is by a punishment inflicted on an individual member of *ogbanje* for contravening the principles of his group. According to B. Osuagwu, and in accordance with what is already seen in the quotation from J.O. Awolalu, before each *ogbanje* member comes to the human world, he usually makes a pact with the other members of his group on when he should return to the *ogbanje* world. Such a pact is usually sealed with a special oath known in Igbo as *iyi-uwa* (the world-oath). Some people promise that they will return in childhood. Some promise that they will return as soon as they finish their academic studies and are about to start work, in order not to be useful to the family that hosted them. Others promise that they will return as soon as they become materially wealthy, in order not to enjoy the wealth. Some of the women members promise that they will return as soon as they get married, without begetting any issue and without being useful to their husbands. Some promise to return as soon as they get a stated number of children to whose training they would not contribute much. Many other forms of promises, are made. Any of these promises once made and sealed with the oath, must be observed to the letter by the individual. A failure to do so would attract a severe punishment from the other members. This punishment is very often given in the form of sickness.[35]

b) *Human Agency*

Nigerians also traditionally believe that sickness can befall an individual through the action of fellow human beings. This can happen in various ways. It could be by poisoning, by means of charms and magic, or by witchcraft.

Poisoning

The use of poison is very common in the whole African traditional society. Apart from use in such activities as hunting and fishing, the people also often use it against fellow human beings. One uses it mainly against rivals, against enemies, and against people who spontaneously rouse one's anger. G. Parrinder remarked, for instance, on the traditional doctors in West Africa: "They are certainly acquainted with some little-known poisons, and perhaps some that are still unknown to science. Some poisons may be given of which the effects are immediate, others produce no visible result for some time, and yet others imitate the symptoms of common diseases." [36]



Muletas incas. Perú

That these remarks of Parrinder apply also to Nigerians has been clearly shown by many authors. For example, C. L. Temple remarked on the people of northern Nigeria that "the people have a great knowledge of poisons of which they make frequent use."[37] And P.A. Talbot said of the people of southern Nigeria, "an extraordinary amount of toxicological knowledge is available in their ranks, and they are certainly acquainted with many poisons as yet unknown to science."[38]

Traditionally, Nigerians are very apprehensive of the possibility of poison, especially when they are dealing with a person not sufficiently known to them or a person whose good will is in doubt. Hence Gustav Equiano remarked on the Igbos of his own time: "The natives are extremely cautious about poison. When they buy any eatable, the seller kisses it all round before the buyer to show him it is not poisoned; the same is done when drink is presented, particularly to a stranger."[39]

Charms and Magic

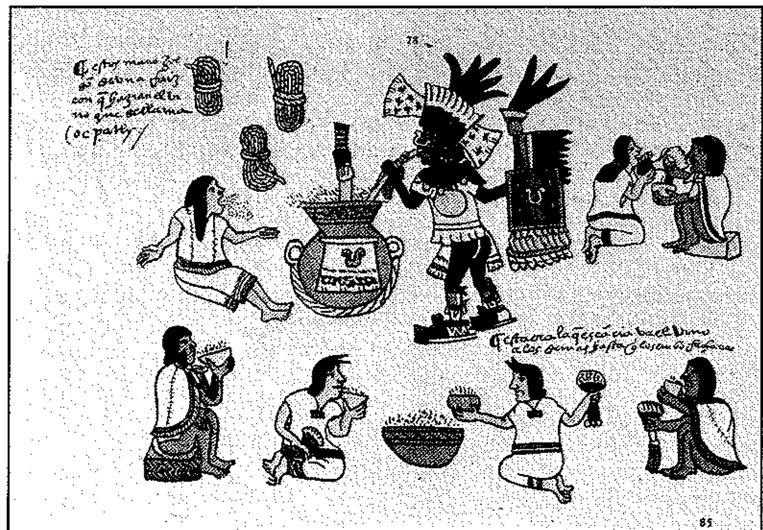
Closely related to poisoning is the use of charms and magic. A charm is an action, object, or words believed to have occult power. And magic refers to "the act of producing marvellous results by compelling the aid of spirits or by using the secret forms of nature, such as the power supposed to reside in certain objects as 'givers of life'."[40] The use of charms and magic is very common in the whole African traditional society. John S. Mbiti affirmed this when he said, "there is no African society which does not hold belief in mystical power of one type or another."[41]

Charms and magic can be used for both good and bad purposes. Accordingly, the members of Nigerian traditional society strongly believe that sickness can be inflicted on an individual by another by means of these.

Sickness can arise through charms and magic in various ways. Sometimes one obtains from a diviner or a medicine man some charms for the protection of one's agricultural fields, cattle, and other forms of property. It is believed that by setting the charm over the property any possible theft or inimical act against the property would be severely punished through the occult power of the charm. Various forms of diseases are regularly attributed to this.

Another magical method of causing harm on others is by a means known in Yoruba as *shigidi* or *sigidi*. A Yoruba dictionary described this as "an image made of mud, believed to have the power of protecting, avenging, and attacking when proitiated."[42] The explanation offered on it by G. Parrinder gives a clearer insight into how it can cause sickness. He said: "One of the most feared Yoruba offensive medicines is shigidi, which is personalized into a demon. The magician makes a rough figure of clay and decorates it with cowrie shells and feathers. Then sacrifices and incantations are made to it, and the evil spirit is called up and sent out to do harm to the enemy."[43]

Nigerians also believe that sickness can befall an individual through a special *calling* of his name by another person. They believe that evil men could procure potent means which would enable them to *call* another person from a certain distance in such a way that if the one called answers, he will be doomed. It is believed that such a call "is charged with evil and is able to call away from well-being."[44] Modupe Oduyoye has pointed out that among the Yorubas the most potent of such a calling is one known as *àpèta* or *à-kpè-ta*, which means "calling to shoot." According to him, it consists in the making of a mud effigy of the prospective victim whose name is then called three times at night, after which the image is shot at three times with a miniature bow and arrow. The wounds inflicted on the moulded image are then believed to be transferred to the body of the desired victim, who would consequently become ill.[45] A similar practice is also reported by P.A. Talbot on the Igbos. He remarked that "some Ibo 'Doctors' drive a nail into the trunk of a tree, into which the soul of the doomed man has first been summoned."[46]



Embriaguez ritual colectiva

Another way sickness can be inflicted on an individual in a magical manner is by an application of a special form of medicine on a waste part of his body, such as a piece of his hair, his finger-nails, spittle, sweat, urine, etc , or on something that was once closely associated with his body, such as a piece of his used clothes, sleeping-mat, washing-sponge, etc. It is believed that if the medicine is applied on any of these materials, it will affect the body of the individual to whom they belonged The people also believe that a person can receive sickness through an action performed on his shadow by another P A Talbot remarked that all the Igbos, except those around Abakaliki and "Obolo," all the Yorubas, all the people of Ijaw, and many Ibibios believe strongly in this For example, he said: "Among the Yorubas a person can be injured or killed by throwing a 'medicine' made of 'alligator' peppers upon his shadow or by slashing at it with a knife. If the shadow hand is touched, the 'medicine' enters into the physical one, makes a big sore and causes blood poisoning, which will bring about his death unless counteracting 'medicines' are obtained." [47]

Connected with magical means of causing sickness is also cursing Cursing is the act of calling down misfortune on persons or things [48] It is magical in character, its effect being thought to be accomplished by the employment of harmful expression, and signs. Africans in general believe in the efficacy of cursing and thus abhor it greatly, especially when it comes from an elder, a stranger, a medicine man, or a man of revered status.[49]

Nigerians believe, too, that sickness can befall an individual through a cursing of him by another person Hence Stephen Farrow said of the Yorubas, and indirectly of all Nigerians: "A curse is greatly dreaded because it possesses this same mysterious power .... The idea is (apparently) that *ogun*, possessed by the speaker (presumably his psychic force), goes forth with words to effect what is prognosticated." [50]

It is also said of some sections of Nigeria that people often go to the grave of a recently deceased person and summon the spirit to arise and strike down their enemy with disease [51] This, too, is magical in character

Witchcraft

Another way in which an individual is believed to be able to cause ill-health to another person in Nigerian traditional society is by witchcraft Belief in witchcraft is very common in the whole of Africa In Nigeria, however, the belief is not found in every part of the country. For example, it is said that the belief is a new development in Igboland and that here it is not yet found in all parts but mainly among the riverain communities.[52]

But what is witchcraft? F. Merzbacher defined witchcraft as "the practice of black magic, sorcery, or intercourse with evil spirits or demons in order, through supernatural aid, to accomplish evil of various kinds " [53] According to Emefie Metuh, however, witches are to be clearly distinguished from sorcerers, whom he described as "those who deal in destructive medicine " He pointed out that "a witch uses no medicines, utters no spells, and performs not rites " He remarked that her powers are inherent in her personality, and so, unlike the sorcerer, "she did not have to learn it like learning a trade." [54] Following this line of argument, he defined a witch as "a person who possesses a special psychic quality which permits her spirit, *obi*, to leave her body, *aru*, while she is asleep to afflict injuries on others or even to eat their souls." [55] In apparent agreement with Metuh's line of thought, J S. Mbiti simply described witchcraft as "a manifestation of mystical forces which may be inborn in a person, inherited, or acquired in various ways."[56] However, Mbiti went on to point out a frequent belief that witchcraft and bad magic are combined and work evil both deliberately and involuntarily on the part of the witch or magician.[57] Therefore, while there seem to be good reasons to agree with E. Metuh and all that reason in the same manner with him that sorcery and witchcraft should be properly distinguished from one another, it remains a fact to be well acknowledged that magic is also involved in witchcraft.

A lot has been written on witchcraft both in the context of the whole of Africa and West Africa and in the context of Nigeria Here is a synthesis of the various pieces of information on how witchcraft operates, especially in Nigeria. It is believed that a man or a woman could be a witch, though in most places women are believed to be in the majority. Usually children are not accused of witchcraft, though a child, especially a girl, may inherit witchcraft from the mother and have it latent within herself. Witches are believed to operate in league, thus making witchcraft a social affair It is believed that at night they leave their body asleep in their various houses, while their souls fly off to a meeting. They could fly on the back of birds, or fireflies, or turn into actual owls, bats, or black cats. It is also believed that if the animal into which they turn is killed, the real body of the witch will die at the same time. It is said that they often fix spider-webs across the doors of their houses so as not to be wakened while their souls are absent. They are believed to hold meetings in hollow or high trees. There they could sit naked or dance in a lewd fashion. As vampires, they are believed to suck blood and to eat the soul of their victims. New members should usually bring a victim, who might be a child of their own family. This they cook together or eat raw When the victim's heart or liver is eaten, he dies.[58]

On how witches could cause sickness, it is believed that often while the body of a witch is asleep in her house, her soul flies off to the house of her prospective victim. To her, darkness is never an obstacle. Here she would pull away the victim's soul to eat or to hide it Any other essential part of the victim's organs may also be taken away by the witch. She does this while the victim is asleep. When the victim awakes he will, as a result of the witch's attack, suddenly fall ill and may die if he is not given due attention Sometimes witches are believed to cause illness by entering the bodies of their victims in the form

of small and crooked animals, such as lizards, crabs, and spiders. This would make the afflicted person complain of creatures crawling round his body and causing him serious pain.[59]

Other Causes of Sickness

Though Nigerians traditionally attribute illness regularly to the unhappy action of supernatural beings and to the wicked acts of some fellow human beings, they acknowledge also that sickness can arise from other sources. They know that sickness can arise out of infection. They know also that sickness can arise out of worry and restlessness of mind. It is also clearly known to them that carelessness in eating and drinking can cause illness. That exposure to bad weather can cause illness is equally not unknown to them. Their acknowledgement of these and other possible causes of sickness is clearly shown by the measures they adopt to preserve their health.

3. *Sickness as Multidimensional*

In Nigerian traditional society, sickness also, like health, is seen as a multidimensional reality. Like health, it is not considered to be restricted to the physical aspect of man. It could arise in any of the dimensions of the human person, such as his physical, psychological, social, moral, and spiritual dimension.

The understanding of sickness as something that is multidimensional is characteristic of the whole of Africa. Accordingly, the African Regional Office of the World Health Organization remarked that "the original African concept of disease is not merely of something resulting from malfunctioning in this or that organ or of a lesion therein, but essentially of a rupture of life's harmony."[60] Noteworthy also is the more detailed remark of Emefie Metuh that for the African "sickness is not simply a biological and physiological phenomenon," but rather something involving physical, psychological, and moral conditions as well as social, spiritual, and ontological relationships. He pointed out that for Africans sickness can arise from a disturbance of the harmony and relationship which each individual should have with God, with the deities, with the living-dead, with the tribe, clan, and the family, and indeed with the whole of nature. In short, sickness "could be at the physico-biological level, at the socio-moral level, at the spiritual level, or indeed at the ontological level, i.e. with nature."[61] He showed, too, that for these Africans the existence of this illness could be "simultaneously at two or more levels, or simultaneously at all the levels."[62]

A good illustration of the multidimensional understanding of sickness in Nigerian traditional society could be found in some Igbo sayings.

An Igbo adage says, *Ahu adighi abughi so nke ana ekelere ndo ma obu na akasi* (Sickness does not consist in only the one that elicits words of sympathy). This is a metaphorical expression which in reality means that sickness does not consist in only physical ailments which are easily recognizable. The Igbos also say, *Ohi bu oria na enweghi ogwu* (Theft is a sickness that has no medicine). By referring to theft as a sickness, they indicate a moral illness. It is a peculiar form of illness which cannot be cured by means of the usual tangible medicine. They say also, *Onye na amaghi onye ka ya bu onye ara* (Whoever does not recognize the superiority of one greater than himself is a mad person). Here the point at issue is lack of proper awareness of oneself and of one's level of capacity. This, therefore, refers to psychological illness. They also say, *Onye na adighi akwadoro umu nna ya bu onye nwuru anwu* (Whoever does not support his kin is a dead man). At issue here is the isolation of oneself from one's family and community. It therefore refers to social ill-health, and the Igbos equate a person who has this to one already dead. They have also a phrase which says, *Ima mma elu ahu ma ree ure na mkpuru obi* (Looking well in the external body but remaining rotten internally). This refers to the situation of being found wanting in the aspect of man considered to be most essential, namely the spiritual aspect. In other words, it refers to spiritual sickness

III. The Concept of Health Care

The traditional concept of health care in Nigeria is, as would be expected, related to the people's understanding of health and sickness. In general, they consider it to be something very important and therefore binding, and something that is multidimensional in form.

1. *Health Care As Important and Binding*

Nigerians traditionally attach great importance to the care of health. This is because of the high degree of value they find in health. Their esteem for health is summarily shown by a Hausa adage which says, *A cikin bukanar duniya, zaman lafiya ita kauna kwowa* (Health is a loving wish of everybody). Accordingly, M. Okpala remarked that "the first thing an Igbo man requests at morning prayer and each time he breaks kola-nut is good health."[63]

Nigerians value their health highly because they consider it to be one af the greatest assets a person can have. They see it as being very basic for whatever work one has to do and for whatever achievement one can attain on earth. They express this conviction with various sayings often used as personal names.[64] For example, the Igbos say, *Ndu-bu-isi* (Health/life is primary);[65] *Ndu-ka-ife* (Health is greater than material objects); *Ndu-bu-uba* (Health is prosperity). The Yorubas say, *Ara to le ni ogun oro* (Health is medicine for wealth); *Alafia l'oju olum gbogbo lo* (Health is more than anything else); *Alafia lo se pataki* (Health is the most essential). The Hausas say, *Lafiya shine arziki* (Health is wealth); *Rashin lafiya rashi-arziki* (Lack of health is lack of wealth); *Lafia uwar kome* (Health is the mother of all). The Isoko people say, *Oma kpokpo ho Efe* (Health is wealth). And the Annang say, *Itong amadu uwem ada kongo nkwa* or *Uwem edi imo* (Where there is health, there is wealth).[66]

Nigerians also value their health highly because of their belief in the sublimity of its origin. They are deeply convinced that it is an essential part of human life, which has its origin in

God. They believe strongly that no human life ever derives its origin from man. Hence the Igbos say, *Mmadu-eke* (Man does not create); *Uzu-akpu-ndu* (A smith never produces life). For them it is rather God who creates everything, including life and health. Hence the Yorubas call God *Elédàá* (The creator), and *Elémìí* (The owner of life)[67] In Urhobo he is called *Omanomohwa* (The moulder-who-moulded-man)[68] The Binis call him *Osanobua* or *Osanobuwa* (The Osa who created living things).[69] The Igbos call him *Chineke* (The God-who-creates), and they further say, *Chi-nwe-ndu* (God is the owner of life); *Chi-na-enye-ndu* (God is the giver of life); *Ndu-si-na-chi* (Life derives from God).

These Nigerians believe that God has given each individual life and health to enable him to achieve the specific purpose for which he has come into the world G. T Basden rightly remarked that the Igbos believe that "God sends men and women into the world for the purpose of fulfilling the functions of life."[70] J. O. Awolalu similarly said, "the Yoruba believe that men's fate is sealed by Olodumare (God) before they come into the world."[71] Making also a similar remark on the Urhobo people, S U Erivwo said: "One of the attributes of God is Omanomohwo; the moulder-who-moulded-a-person This moulding happens before Omena (a divinity) in *erivwin,* the spirit world. Subsequent to the moulding, the person moulded appears in an arena at *erivwin* to declare his destiny. He does this in the presence of a crowd of *irhi* (plural of *erhi*, spirit) stating what he would like to be and do on earth ... Once the destiny has been sealed, the person embarks on his voyage to *akpo* (world) with his canoe fully loaded with all he said he would be and do on earth."[72]

Following the above and other possible reasons, Nigerians traditionally always feel bound to take good care of their health They would generally prefer to remain in a state of want of either food or drink rather than taste anything that might be injurious to their health Hence the Igbos say, *Kama ri jue afe dachie uzo, ka m bulu onu* (Rather than eat well and by so doing fall by the wayside, let me remain hungry). And the Hausas advise one another saying, *A yi hankali, kada a sha ruwa da haki* (Be sensible; do not drink water with grass).[73]

2. *Health Care as Multidimensional*

In Nigerian traditional society, health care, like health and sickness, is also understood to be multidimensional The people do not theorize on this; they simply show their conviction by practical action. They see health care as involving diversity of acts. For them it involves both protective and restorative acts. It also involves acts that cover good attention to the various dimensions of the human person, namely, the physical, psychological, social, moral, and spiritual dimensions. Accordingly, Emefie Metuh remarked that for the Igbos the medicine man is not just a physician but is also a psychotherapist and spirit-healer.[74] He also made the same remark on the whole of Africa, saying, "Since sickness for Africans is a physical as well as a psychological and spiritual experience, a medicine man is at once a physican, a psychiatrist..., and a performer of rituals"[75] A similar remark is also found in John S. Mbiti who said, "Disease is not just a physical condition, according to African interpretation and experience. It is also a religious matter. Therefore, to deal with it people revert to religious practices."[76]

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[1] The Catholic Bishops of the United States, *Health and Health Care*, A Pastoral Letter, 19 November 1981 (Washington, D.C: United States Catholic Conference, 1982), p 3

[2] Cf. Elizabeth Isichei, *A History of Nigeria* (London: Longman, 1983), p 485.

[3] Andrew G Onokerhoraye, *Social Services in Nigeria An Introduction* (London: Kegan Paul International, 1984), p. 118

[4] Cf. Neil Skinner, *English-Hausa Illustrated Dictionary* (Zaria: Northern Nigeria Publishing Co, 1965), s.v. "Health;" Paul Newman & Roxana Newman, eds., *Modern Hauas-English Dictionary* (Ibadan: Ibadan University press, 1979), s.v "lafiyà."

[5] *Dictionary of the Yoruba Language. English-Yoruba. Yoruba-English,* new and enlarged edition (Lagos: Church Missionary Society Bookshop, 1981), s.v. "health" "healthy" "didá-ara," "tagun"

[6] Cf. Emefie Ikenga Metuh, *God and Man in African Religion* (London: Geoffrey Chapman, 1981), p 85.

[7] Kofi Appiah-Kubi, "The Akan Concept of Human Personality," *in Traditional Religion in West Africa* ed. E. A. Ade Adegbola (Ibadan: Daystar Press, 1983), p 261

[8] Cf. Matthew G. U. Aquaowo, "Health (Healing) in Traditional Nigerian Society" (M A. Dissertation, Katholieke Universiteit, Leuven, 1985), p 6

[9] Cf. *Chamber Twentieth Century Dictionary*, 1977 ed., s v. "evil"

[10] Cf. P Newman & R. Newman, *Modern Hausa-English Dictionary,* s v "ciwo"; N. Skinner, *English-Hausa Illustrated Dictionary,* s v "illness," "sickness"; M. Landeroin & J Tilho, *Dictionnaire Haoussa* (Paris: Imprimerie Nationale, MDCCCCIX, s.v. "maladie," "malade," "rasa"/"rashi," "da," "lafia," "chiwo."

[11] Cf *Dictionary of the Yoruba Language*, 1981 ed., s.v. "sick," "sickness," "alarun," "lailagbara"; Bishop Crowther, *A Vocabulary and Dictionary of the Yoruba Language* (London: Church Missionary Society, no date), s.v. "sickness," "sick," "aron."

[12] G T. Basden, *Niger Ibos* (London: Frank Cass & Co, 1966), p 50

[13] Cf. C L. Temple, ed, *Notes on the Tribes, Provinces, Emirates and States of the Northern Provinces of Nigeria* (London: Frank Cass, 1965), p 147.

[14] J O. Awolanu, *Yoruba Beliefs and Sacrificial Rites* (Harlow: Longman, 1979), pp 179-180

[15] Mucizz Goriawale, "Maguzawa: The Influence of the Hausa Muslims on the Beliefs and Practices of the Maguzawa, the Traditional Religionists of Kano and Katsina," in *The Gods in Retreat. Continuity and Change in African Religions*, ed E I Metuh (Enugu: Fourth Dimension Publishing Co, 1986), p 50.

[16] *Ibid*., p. 53.

[17] D. R. Price-Williams, "A Case Study of Ideas Concerning Disease Among the Tiv," in *Peoples and Cultures of Africa*, ed Elliot P. Skinner (New York: Double Day/Natural History press, 1973), p. 363.

[18] J. O. Awolalu, *Yoruba Beliefs,* p 156.

[19] G T. Basden, *Among the Ibos of Nigeria* (London: Frank Cass, 1966), p. 225. See also id., *Niger Ibos*, p 63

[20] A G. LEONARD, *The Lower Niger and Its Tribes* (London: Macmillan, 1968), p 253.
[21] I M. ODINKEMELU, *Mammy Water in the Society: Her Influence in Igbo Culture* (Ihiala: Sams press, 1986), p 12.
[22] Cf. *ibid.*, pp. 12-15, 19-22; EMMANUEL M P. EDEH, *Towards an Igbo Metaphysics* (Chicago: Loyola University Press, 1905), p 107.
[23] GEOFFREY PARRINDER, *West African Religion* (London: Epworth press, 1969, p 116
[24] M. Y NABOFA, "Erhi and Eschatology," in *Traditional Religion in West Africa*, ed. E A A Adegbola, p 310
[25] ROBERT I PARSONS, ed., *Windows on Africa* (Leiden: E J Brill, 1971), p. 96.
[26] C L. TEMPLE, ed., *Notes on the Northern Provinces*, p 12.
[27] Cf *ibid*, pp 144, 317 & 358.
[28] G. T. BASDEN, *Niger Ibos*, p. 63
[29] M. G. U. AQUAOWO, "Health (Healing) in Traditional Nigerian Society," p 62.
[30] *Abiku* is also known in Yoruba as *Elére* or *Emeré*, or as Eléréè Elégbé. Cf E. BOLAJI IDOWU, *Olodumare: God in Yoruba Belief* (London: Longman, 1962), p. 123; J. O AWOLALU, *Yoruba Beliefs*, p 159
[31] EDMUND ILOGU, *Christianity and Igbo Culture* (New York: Nok Publishers, 1974), p 42.
[32] J O AWOLALU, *Yoruba Beliefs*, p 159.
[33] M. Y NABOFA, "Erhi and Eschatology," in *Traditional Religion in West Africa*, ed E A A Adegbola, p 312.
[34] BERTRAM I. N. OSUAGWU, *Ndi Igbo na Omenala ha* (Lagos: Macmillan, 1978), p 42
[35] Cf *ibid.*, p 28.
[36] G PARRINDER, *West African Religion*, p 156.
[37] C L. TEMPLE, ed., *Notes on Northern Provinces*, p. 178.
[38] P A TALBOT, *The Peoples of Southern Nigeria*, vol. II (London: Frank Cass & Co, 1968), p. 162
[39] PAUL EDWARDS, ed, *Equiano's Travels* (London: Heinemann, 1967), p 14
[40] *Chambers Twentieth Century Dictionary*, 1977, cf the entries *charm and magic*
[41] JOHN S. MBITI, *African Religions and Philosophy*, London, Heinemann 1969, p 197
[42] *A Dictionary of Yoruba Language*, (Ibadan: Oxford University press, 1970), s.v "sigidi"
[43] G. PARRINDER, *West African Religion*, p. 163.
[44] MODUPE ODUYOYE, "The Medicine Man, the Magician, and the Wise Man," in *Traditional Religion in West Africa*, ed E A A Adegbola, p. 62.
[45] *Ibid.*
[46] P. A. TALBOT, *The Peoples of Southern Nigeria*, vol II, p. 180 See also id, *Tribes of the Niger Delta* (London: Frank Cass & Co., 1976), pp. 131 & 139.
[47] ID., *The Peoples of Southern Nigeria*, vol. II, p. 183.
[48] Cf *New Catholic Encyclopedia*, 1967 ed, s.v. "Curse," by W. Dupré.
[49] Cf. J S. MBITI, *African Religions and Philosophy*, p 211
[50] STEPHEN S FARROW, *Faith Fancies, and Fetich or Yoruba Paganism* (London: Society for Promoting Christian Knowledge, 1926), p 119.
[51] Cf P A TALBOT, *The Peoples of S Nigeria*, vol. II, p. 182
[52] Cf. F. C OGBALU, *Omenala Igbo (The Book of Igbo Customs)* (Onitsha: University Publishing Co, 1979), p 75; E. ISICHEI, *A History of the Igbo People* (London: Macmillan, 1967), p 6.
[53] *New Catholic Encyclopedia*, 1967 ed, s v "Witchcraft," by F Merzbacher
[54] E. I. METUH, *God and Man in African Religion*, p 100
[55] *Ibid.*
[56] J. S. MBITI, *Introduction to African Religion* (London: Heineman, 1975), pp 165-166
[57] *Ibid.*, p 166
[58] Cf., for example, J Akin Omoyajowo, "What is Witchcraft?" in *Traditional Religion in W. Africa*, ed E A A Adegbola, pp. 317-335; G. PARRINDER, *West African Religion*, pp 165-169; J S. MBITI, *Introduction to African Religion*, pp 165-167; E I. METUH, *God and Man in African Religion*, pp. 100-102 Some pieces of information were also personally received on this at Ogwu-Ikpele and Nsugbe, which are among the few places in Igboland, where the practice of witchcraft is rife. Some of the informants claimed to have been personally bewitched and lured to the meetings of witches for some specific reasons.
[59] Cf. G PARRINDER, *West African Religion*, p. 168; J. O AWOLALU, *Yoruba Beliefs*, p. 85.
[60] WHO, *AFRO Technical Papers*, no 12 (Brazzaville: Regional Office for Africa, 1978), p. 40.
[61] E I. METUH, "African Traditional Medicine and Healing: A Theological and Pastoral Reappraisal," in *Lucerna*, vol. 6, no 1 (January-June 1985), p 8.
[62] *Ibid.*
[63] M M. OKPALA, "The Igbo People and the Search for Security" (Licentiate Dissertation, Accademia Alfonsiana, Rome) 1982, p 17
[64] In the whole of Africa, personal names are generally expressive of very important feelings and ideas Hence Ebo Ubahakwe said, "An indigenous African name on the whole personifies the individual, tells some story about the parents and/or the family of the bearer, and, in a more general sense, points to the values of the society into which the individual is born" EBO UBAHAKEWE, "Culture Content of Igbo Personal Names," in *Igbo Language and Culture*, vol II, ed F. C Ogbalu and E. N Emenanjo (Ibadan: University Press, 1982), p 27.
[65] The English words "health" and "life" are often rendered in Igbo by the same word "ndu."
[66] M. G. U. AQUAOWO, "Health (Healing) in Traditional Society of Nigeria," p. 5
[67] Cf J. O. AWOLALU, *Yoruba Beliefs*, p. 11.
[68] Cf. S U. ERIVWO, "Traditional Religion and Christianity among the Urhobo," in *The Gods in Retreat*, ed E I Metuh, p. 22.
[69] MODUPE ODUYOYE, "Names and Attributes of God," in *Traditional Religion in West Africa*, ed E A A Adegbola, p. 351
[70] G T BASDEN, *Among the Ibos*, p 118
[71] J O AWOLALU, *Yoruba Beliefs*, p 23.
[72] S.U ERIVWO, "Traditional Religion and Christianity among the Urhobo," in *The Gods in Retreat*, ed, E. I Metuh, p 31
[73] A H. M. HIRK-GREENE, ed, *Hausa ba dabo ba ne A Collection of 500 Proverbs* (Ibadan: University Press, 1966), n 14: pp 14 & 22.
[74] E I. METUH, *African Religions in Western Conceptual Schemes The Problem of Interpretation (Studies in Igbo Religion)* (Ibadan: Pastoral Institute, 1985), p 162
[75] ID., "African Traditional Medicine and Healing," in *Lucerna*, vol 6, no. 1, p 9
[76] J S. MBITI, *Introduction to African Religion*, p 134

Medicine and the *Conquistadores*

Fifteenth-century Spain fruitfully developed medical science, which was notably spurred when Ferdinand of Aragon authorized the Confraternity of physicians and surgeons of Saints Cosmos and Damian to "open and dissect the bodies of the men and women who died at their hospitals" The analyses and autopsies practiced from then on enabled anatomy to be studied in depth and opened up new horizons for physiology, above all offering the possibility beginning in the early sixteenth century of perfecting surgical techniques and operating methods.

To this medical revolution permitting the replacement of Galen's comparative anatomy, making possible the surgical treatment of fistulas, and improving pharmacopoeia there was added the reorganization of the "Protomedicate." To this tribunal, which was granted authority to specify functions, set the limits for action by physicians and surgeons, and impede the illegal practice of medicine, the enormous stimulus which the medical schools of the period (Valencia, Cádiz, Madrid, Barcelona, etc) received was due

In those years an interesting series of medical publications in Spanish had already appeared: *Epidemic and Plague* by Velasco de Taranta (1445); *Therapeutic and Preventive Medicine for Pestilence* by Diego de Torres (1485); *A Compendium of Medicine and Surgery* by Guillen de Brocar (1495); and *Stone Treatment, Liver Pain, and Renal Colic* (1498), etc

The "Catholic" monarchy tenaciously combatted quackery, but it was then, as it continues to be today, a weed loathe to disappear, and then, as today, the *curanderos*, or quack healers, created a good many medicines, to the point of getting doctors to accept them. The latter, for instance, declared themselves to be powerless before the illness of the great Cisneros, but an Arabian syrup cured him both quickly and unexpectedly, in spite of the fact that he was over eighty.

Let us not forget that Emperor Charles V, who had none other than Vesalio at his side, believed in amulets and talismans. In the inventory of his belongings we find the following objects:

— stones inlaid with gold to treat hemorrhages;

— two bracelets, a gold ring, and a ring of bone with special effects on the blood flow;

— a bezoar stone from the Orient, a philosopher's stone, etc.

This was the medicine of the Spain the New World was exposed to in the early years of the conquest, and it was undoubtedly an exchange of experiences bearing on the art of medicine which made possible mutual enrichment.

There were very few Spanish doctors and surgeons who went to the New World, but those who did so took with them science and experience which they disseminated generously, exposing their lives to the privations they were forced to undergo, obliged as they were on various occasions even to take up arms to defend themselves from the attacks of savages.

European medicines encounter with the New World's was not a clash but an embrace in which the two became wonderfully integrated With intelligent comprehension, the Spanish physicians assimilated the empirical medicine of the "American savages," and, according to Furlong, "it was the Europeans who benefitted most therefrom."

R. Pardal recalls that among the leading consequences of the discoveries of European medicine were:

1) an enormous enrichment in materials through New World substances such as jalap, Peruvian and tolu balsam, coca, retania, May apple, cocaiba, etc.;

2) the publication of treatises, new editions, and special chapters introduced into books of the period on indigenous medicine, printed in Spain and later in America in the sixteenth century;

3) a change in ideas on the modus operandi of certain drugs which contradicted the scholastic, Aristotelian, and Galenic medical doctrines absorbed from an exaggerated "Arabism";

4) the sending of scientific expeditions to the New World, the first of which was organized by the general medical commission for the Indies

The conquest had different results in the field of medicine in the Viceroyalties of New Spain and Peru in the first half of the sixteenth century and later in that of Río de La Plata.

Aztec medicine gives us an example of the former. The Aztecs came from Aztlán and settled in the Valley of Mexico on the shores of Lake Texcoco in 1267 A.D., after wandering for nearly a century. They had been preceded by the Olmecas, Toltecas, and Chichimecas towards the end of the twelfth century. Tenochtitlán, the Aztec capital, was founded in 1325, and this date marks the Mexican expansion which culminated on the eve of the Spanish conquest in 1519 It is possible to understand many cultural and medical aspects only if we probe the hard process of Mexican adaptation to an arid ecology in the midst of hostile ethnic groups

The doctrines and medical practice of the Aztecs were imbued with profound religious elements; they believed in hea-

ven, in the sun (*tonatiu*) reserved for heroes.

The mother of the gods, Toci, was the goddess of medicine, worshiped by physicians, surgeons, phlebotomists, midwives, and the women who took herbs in order to abort.

Aguirre has analyzed the religious and psychological factors in relation to Aztec medicine and deriving from their social structure, severe military discipline, and children's dependence on their fathers. These aspects are also witnessed to by the Mendocino Codex.

Aztec medicine enjoyed great prestige among the pre-Colombian civilizations, for it assimilated the positive contributions of the areas subject to conquest. Fr. Clavijero tells us that medical science and practice were hereditary that is, they were handed down from father to son.

They instructed their sons on the nature and variety of the ailments to which the human body is subject and the knowledge which divine Providence has created as a remedy, whose virtues have been experienced by the elders. They taught them how to distinguish among the different degrees of the same illness, prepare medicines, and apply them While the father was still alive and still physically and mentally capable, the son did not practice, generally limiting himself to functions as a helper.

Whoever practiced clinical medicine was called Tlama, Tepaati, and Ticite and used drugs, external applications, and material instruments Whoever was experienced in surgery and traumatology bore the term Toxoxolatlic alongside his own name, just as phlebotomists, experts in obstetrics, and others also had their own titles. There was undoubtedly a perfectly established professional specialization. Motolinia, who so closely studied and knew the sons of the Aztecs, wrote, "They have many hospitals, where they care for the sick and the poor They also have special doctors who experiment and apply many herbs and medicines, which are sufficient for them. Some of these Indians have such experience of many serious illnesses that they are

able to care for Spaniards unable to find a remedy for their diseases "

It would be quite lengthy, but no less interesting, to examine their clinical art and their magical diagnostic techniques, as described by Sahagún and La Serna (1956), as well as the discovery of surgery, their surgical techniques for therapeutic purposes and to produce mutilations for a religious, military, social, or aesthetic end, such as facial plastic surgery, dental operations, perforation of the nasal septum, ear lobe, or lower lip, where they inserted precious materials such as jade, turquoise, and gold.

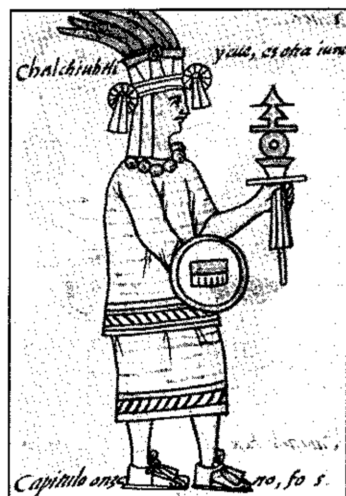
The therapeutic substances were varied and numerous; a study is found in the Badiano Codex and Sahagún. The latter reserves a chapter entitled "On the Illnesses of the Human Body and the Medicines to Treat Them," in which he refers to medicinal stones and 251 curative plants. As Francisco Guerra affirms, "The best tribute which pre-Colombian medicine could receive flowed from the pen of the *conquistador* Fernando Cortés, when he asked Charles V not to allow Spanish medicines to be introduced into Mexico, since the ability and knowledge of Aztec medicine made them completely useless."

In the Viceroyalty of Peru, the Spanish conquest also had dealings later with Incan medicine.

Incan civilization occupied the Andean region on the coast and the equatorial altiplano beginning with the conquest of Tiahuanaco in 1445 A.D., but its great splendor came after 1470.

The dominion of the Incas surely lasted less than a century, for the Spanish conquest of Peru began in 1531.

Incan civilization was characterized by ideals of a socialistic type and by absolute despotism centering on the Inca, who, incarnating the Sun God, reigned over the priests, nobility, and people organized into clans. The theogony of the Incas holds that Viracocha (God the Creator and Sun) sent his eldest son Ymaimana to show people that herbs were good as food and which could be used as medicines



They worshiped the sea, Marmacocha, so as not to get sick or to ask for the health they had lost. In their religious life they devoted a lot of attention to the Huacas, spirits that could take possession of any object or person and exerted great influence on destiny, health, and diseases.

Among the Incas, the physicians of the Sun God, the Hampi Camayoc, passed on knowledge from father to son. Garcilaso tells us that "the Indians were great herbalists, for they knew the powers of many herbs and passed on their secrets from father to son." The leaders also designated those who could practice medicine, selecting them as far as possible from among those who had eluded lightning bolts and serious accidents, or those who displayed a vocation as a medicine man.

In diagnosis of illnesses magical procedures were used; there is mention of heaps of corn which, on losing their kernels, yielded a good or bad result depending on whether the kernels were even or odd, or the practice of reading destiny from piglets' entrails.

They identified illnesses exclusively by their symptomatology: hemorrhages (*usputay*), abscesses (*chupu*), pus (*quesa*), and so on. There are also descriptions of chronic illnesses like endemic tumor (*coto*) from a lack of iodine in the diet, cutaneous leishmaniosis (*uta*), dysentery (quite frequent on the coast), and intestinal parasitosis (*cuycaitta oncoy*).

Dr E. Treves, on the basis of accounts by chroniclers like the aforementioned Garcilaso and Puma de Ayala, along with the writings of P. Calancha, asserts that the natives of ancient Peru were familiar with smallpox and that Huayna Capac died on account of this illness when the Spaniards reached the Gulf of Guayaquil.

They were also familiar with epilepsy, and the wife of Capac Yupanaqui is said to have been an epileptic who, in the midst of an attack, bit her son to death. As for surgical knowledge, we can state that they used specialized instrumentation like the tumi, consisting of a knife with semicircular ends obtained from a mixture of gold, silver, and copper highly resistant instruments, and scalpels, but especially knives, pocketknives, and saws of obsidian and flint, found at Paracas and described for us by Weis (1949). They built foot protheses and amputated members, but the most important activity was cranial drilling enabling them to treat the frequent wounds received in warfare from stones and clubs or practiced for magical purposes.

They were expert embalmers carrying out different procedures to preserve the body, checking the process of putrefaction by simple exposure to the cold in the high mountain areas or drying out cadavers close to a fire. They also used chemical methods.

The experts maintain that in some instances of embalming methods quite similar to those practiced by the Pharaohs can be detected.

As regards their therapeutic arsenal, it should be stated that it was abundant and quite varied. They used materials especially of vegetable origin purchased in certain markets (hampicatu) or from herbalists or itinerant doctors offering their wares. The Inca Pachacutec was said to have gloried in the fact that he was familiar with most medicinal plants. Among those used most frequently we find *huachanca*, with a purgative property, *chilca*, which, when taken after being cooked, serves to treat insomnia and malaria, passionflower, for the treatment of diarrhea, corn stigma as a diuretic, and *alcoquisca* for liver ailments.

The most important plant among the Incas was coca, cultivated in the community's *chácaras*; when chewed, it caused weariness, hunger, and thirst to disappear and stimulated the intellect.

These properties to which use as a local anaesthetic and stimulation of the cerebral cortex should be added did not prevent Gutiérrez Noriega e Zapata (1948) from asserting that coca was responsible for the mental degeneration and frequent psychological disturbances of the Incas.

Among therapeutic animal substances they used the bloody

flesh of the vicuna for inflamations of the eyes caused by snow

The fat of the American ostrich and the condor were ointments for the feet of gout sufferers.

As for mineral substances, we find the application of mud to numb areas and copper sulphate for cicatrization of wounds and a sulphur base mixture for scabies. What did Pedro de Mendoza and the 2,000 men making up his expedition find at the end of the Río de la Plata? Many centuries before the arrival of the Spaniards there was a people widely distributed in the region of the pampas. The environment gave them their name Their extinction began at the beginning of the eighteenth century, when they were replaced by Araucanian groups coming from Chile presenting themselves as pampas. The pampas tribes recognized each other only by their *caciques*, for they no longer had a fixed dwelling

The most well-known aspect of these Indians involved the indigenous women (*querandies*) with whom the early discoverer and colonizers arriving with Pedro de Mendoza had contact, requesting food to combat the famine accompanying the initial foundation of Buenos Aires in February 1536 And it was they, too, together with the Guarani, who occupied and set fire to Buenos Aires.

Tupi-Guarani medicine was far removed from the progress found in the Aztec and Incan civilizations. The Guarani, who occupied a huge area of South America, spread into our country from the Paraná delta to Corrientes, Misiones, Chaco, and the western part of the Republic of Paraguay. They weighed heavily upon the other native peoples and the white population throughout the Spanish period They had their doctors and medicines, almost all of which consisted of the use of bark, seeds, and juices from plants and trees in the region. Among their medical practices, Pardal remarks, were incision and the application of ointments.

"Every day, after bathing, they rubbed over their bodies an ointment obtained from the coloring material of Bixa Orellana seeds to protect themselves from the sun and mosquitos " Fire treatment among the Guarani was as effective as it was painful. In *O Salvagen* General Couto de Magalhaes narrates, "They used fire as a therapeutic substance against the bites of poisonous animals, such as vipers and devil fish They did not cicatrize as we do, but brought fire as close to the wound as the patient could stand.... " To treat stomach pains they used alkaline carbonates in powdered form which they called *piha-ai* (a white, very fine powder they obtained by burning and then grinding the shells of the Río Itavambá oysters).

Like most of the American natives, they generally tended to treat wounds by applying medicinal plants, such as tobacco, Ficus-Guapoi, Copaiba or Kupahi, etc They did not push on into the field of surgery, but did advance in immunology, using a preventative injection consisting of having themselves bitten by a snake with the weakest venom. The Guarani of Paraguay had themselves bitten by the snake known as *Nakanina* as a preventive measure for other bites by more poisonous snakes.

Finally, according to Francisco Guerra, "the establishment of Spanish health facilities in America after the Conquest coincided with the most brilliant period of Spanish medicine.

On account of its solid foundations, the New World did not suffer so much from Spain's scientific collapse in the seventeenth century; hospitals, instruction, and medical practice continued to flourish until reaching the highest level during the reign of Charles III, at the end of the eighteenth century. "

In conclusion, it can be affirmed that in the halls of Lima anatomical-clinical cases were discussed just as they were in Paris. All of this interest in academic medicine did not, however, lead in all instances to the health of the American peoples. It is not possible to provide an in-depth interpretation of colonial medicine in Spanish America when prescinding from its profound meaning of Christian charity

There are three men who must necessarily be remembered with special consideration in the history of Spanish American colonial history: St. John of God (1495-1550), whose Brothers of Charity followed in America the hospital norms initiated in Granada; Bernardino Alvarez (1514-1587), who at St. Hippolytus Hospital in Mexico began to treat psychiatric patients in 1567 and created the Order of the Hippolytes and numerous medical facilities in America; Pedro de Bethencourt (1619-1667), who, after founding Our Lady of Bethlehem Hospital for convalescents in Guatemala in 1657, created the Order of the Bethlehemites But the religious influence of Spanish American medicine went beyond the hospital orders. Colonizers and creoles in general received the care of doctors trained according to classical doctrines learned in university halls, where, as we have already seen, humoral pathology and therapeutic medicine based on purgatives and bloodletting were dominant. The American natives remained faithful to the idea of illness as sin and to the use of medicinal plants, whose real virtues resided in the therapeutic power of the organism.

Without a doubt and this is historically important both sectors of the Spanish American colonial population faced illness with the support of deep religious faith. The Spanish, with their centralized Catholicism, and the natives, with the syncretism of their ancestral divinities within Catholic theology.

It was precisely in seventeenth-century Spanish America that there arose a baroque medical-religious approach wherein prayers for the cure of illnesses addressed to the Mother of God and the saints impregnated all medical practice. But this is another story... Following Ganiver, we recall that "conquering, colonizing, and civilizing are, after all, nothing but infusing love for the road ennobling man, saving him from the state of tranquil ignorance in which he would live eternally."

Prof. HUGO O.M. OBIGLIO

Vice President
International Federation of Catholic Medical Associations (FIAMC)

Testimony

Exploración médica. Cerámica mochica, Perú

Witnesses to Charity in Service to the Sick

Hospital Activity in the Sovereign Order of Malta

Material for Elaborating an Apostolic Project in Common

Pharmacopeia and African Traditional Medicine

Witnesses to Charity in Service to the Sick

1. Charity to the point of Martyrdom

Seventy-One St. John of God Brothers Beatified by John Paul II on October 25, 1992.

In reviewing the biographies of men and women whose sanctity has been recognized by the Church, our predominant sentiment is admiration.

On reading the vicissitudes of the seventy-one religious of the Hospital Order of St. John of God martyred in Spain between 1936 and 1939, our immediate, dominant reaction is to be deeply moved

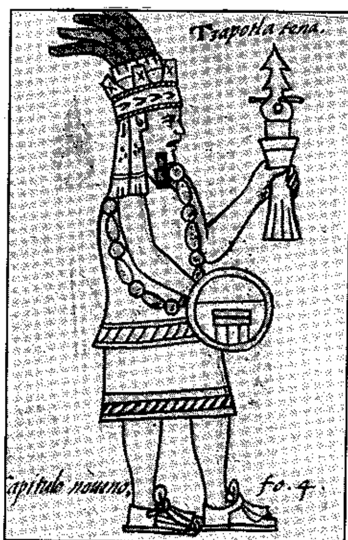
The courage and abnegation of these martyrs stand out at a dramatic moment in the Spanish Civil War and pose the question of the unimaginable negative consequences of the perversion of intelligence placed at the service of the blindest hate

The seventy-one religious martyred were regarded by their persecutors as a symbol to be brought low they represented an opposing force. They certainly were, but only from the standpoint of those barbarously cutting short their lives.

In their lives what counted was not the extraordinariness of their normal being, but the normality of their being extraordinary to the point that people's love for these servants of the sick was so extensive that it checked the cruelty of their enemies' rage. They showed no class discrimination in receiving and assisting the sick at their hospitals.

The anarchy which had led to the breakout of civil war in Spain and the first acts of absurd violence perpetrated against religious institutions had forced the Spanish communities of the Brothers of St. John of God to question whether they should remain on this risky battleground or prudently withdraw

The adage of the manuals of morality, *Ad actus heroicos nemo tenetur* ("No one is obliged to perform heroic actions") presents itself as immediately applicable, but it was not to be read in either the rule or the life of St. John of God. The problem was, however, seriously debated. This was the decision made: on April 4, 1936 the then Superior General of the Brothers of St. John of God, Brother Narciso Durchschein, sent the Spanish communities of his religious a circular letter in which, among other things, the following words appeared, which, at a distance of sixty years, resound as a significant warning: "We have carefully observed and examined the very serious political situation in Spain. .. Our religious shall not abandon attention to the sick until the authorities assume responsibility for them..... Let them remain at the side of the sick until circumstances beyond their control force them to abandon them. "



The lesson flowing from this episode poses the extent and significance of the care of the sick which the Church, following the example of her Divine Master, regards as an integral part of her mission

In the year in which the Holy Father has instituted the World Day of the Sick for the Universal Church seventy-one religious who exercised a witness of heroic charity in care of the sick to the point of martyrdom have been beatified.

With the beatification of the seventy-one Spanish hospitaller martyrs, health workers and those devoted to medical and pastoral care among the sick ought to feel stimulated to regard their profession, vocation, and mission as extremely important and the most credible Christian witness.

But through the religious of St. John of God who accepted living out their vocation to the point of martyrdom another counsel comes. The crisis in priestly vocations and those of special consecration afflicting the Church in our time can be responded to constructively by recovering the healthcare ministry, of particular interest today in the face if the "new maladies" wreaking havoc. A counsel affecting the whole Church community, since, as the Holy Father reminds us, "in the loving, generous acceptance of every human life, especially if weak or sick, the Church is today living out a fundamental moment in her mission," all the more necessary the more dominant is the "culture of death" which has been formed.

FIORENZO Cardinal ANGELINI

2. Concern for the Sick

Spanish-born Augustinian Father Ezequiel Moreno was canonized in Santo Domingo on October 11, 1992

The biographical landscape of Father Ezequiel is populated by the sick. It was often his destiny to live at their side, and he always kept them present in his heart. As a child he preferred to give up the "calves" of St Rocco

in order not to leave a sick companion alone. In his final illness, when his strength scarcely kept him on his feet, he still found the energy to visit and comfort the sick admitted to the room of the poor at the clinic where he had just been operated on.

Between those two scenes there passed a whole life devoted to the service of suffering humanity.

He was always available to rush to hear confessions, relieve pain, and provide assistance for material needs

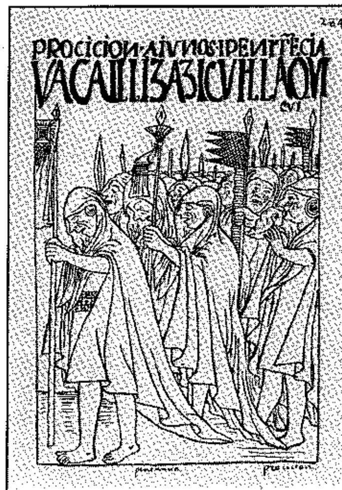
But his solicitude shone forth especially in his travels, during which he never neglected to ask about the sick in the places he passed through or in epidemics which mark a great part of his life and take them a word of consolation. Let us not forget that he undertook his priestly ministry in a military colony tormented by malaria and that he thereafter had to administer towns devastated by smallpox, cholera, and famine

He was concerned, above all, about the souls in his care.

If he was able to purify them with the sacrament of Penance, he exulted with joy and glorified the Lord. If he met with some resistance, he suffered, flagellated himself, increased his prayer, and insisted once more. He also paid attention to other, more earthly exigencies, however. He knew that the sick needed company, understanding, human warmth, and encouragement and strove to give them these things. He deeply shared in their pain and often succeeded in attenuating it or even transmitting courage and the joy of living to both the sick and their relatives

A. MARTALLES

Enfermos suplicando salud a los dioses
Códice Tudela



3. Inner Wealth, Love, and Sacrifice

María Josefa of the Heart of Jesus Sancho de Guerra, Foundress of the Servants of Jesus of Charity, Beatified on September 27, 1992.

I quiver with emotion on attempting to say something about Mother María Josefa of the Heart of Jesus and her work, the Congregation of the Servants of Jesus of Charity

The heart of that woman, in tune with the Heart of Jesus, did not shrink before the hardships added by the social and political environment: the Carlist war; a dramatic situation among workers with the onset of modern industrialization; the successive scourges of cholera, typhus, and smallpox; defeatism over the loss of the colonies; and movements marked by rabid aversion to the Church. Mother María Josefa of the Heart of Jesus did honor to her name and was not content to lament so much need and indigence: she simply became an instrument of God's love and poured out love upon those needing it most. She did not want to be the only one, but served as a guide for other young women, whom she directed wisely in the same task of the Church

Forty-two houses were opened in the lifetime of the Foundress herself. We lack the space here to recount the heroic activity of those sisters formed by Mother María Josefa of the Heart of Jesus, who were even capable of laying down their lives in service to the sick. What an immense and, generally speaking, silent apostolic effort! At present our Mother continues to watch over her daughters from heaven. The Congregation has 78 houses, 811 professed religious, 120 junior sisters, 62 novices, and 40 postulants. They live out their charism in thirteen nations in Europe, the Americas, and Asia. The motherhouse is in Bilbao, Spain, and the generalate, in Rome. It is structured into five provinces, in addition to the general delegation, two Spanish and three American. The European provinces share a novitiate in Burgos, and the American ones have their own in Buenos Aires; Armenia, Colombia; and Mexico City.

The Servants of Jesus work at nursing homes, nurseries, dispensaries, and hospitals. But most of them, in the evening, protected externally by their sacred habit and internally by the spiritual armor of the Lord, whom they serve, go like angels in the night to "watch over the sick."

Sister MERCEDES MIGUEL
Superior General

The Hospital Works of the Sovereign Order of Malta Today

There are different reasons why it is not easy to give an even restricted survey of the worldwide activities of the Sovereign Order of Malta. As the activities are planned and realizad in a decentralized way by the Priories and the National Associations, and as they have developed in accordance with the local needs and possibilities, further systematic structuring is difficult. An analysis of the worldwide activities of 1989 has for the first time permitted a reliable survey of the Order's work According to the Order's tradition, the focus lies on the medical field, but the activities include socio-medical assistance

Naturally such a statistic cannot record the great number of individual activities which have been realized privately by many members of the Order outside the institutional scope. This may easily lead us to underestimate their importance, but many of those individual acts of assistance stand out for their devotion to the helpless and fulfill the Order's task, *obsequium pauperum,* in an exemplary way. The complete representation of the SMOM's Hospitality today is the result of the existence of both the great institutional works and the individual activities

1. Short Survey of the History and Today's Organization of the SMOM

The Sovereign Military Order of Malta—Hospital Order of St John of Jerusalem, of Rhodes and Malta, as the full name reads recounting the story of the Order's central migration, was founded in the 11th century and is the oldest and the only existing Order of Knighthood in continuous tradition. It started in Jerusalem where Bl. Gerard († 1120), the first superior of the confraternity, administered a flourishing hospice-infirmary, which was in the neighborhood of the church of St John the Baptist, when the first Crusaders arrived in 1099. Many Crusaders joined the community and started to turn it into an Order of Knighthood, which besides caring for the sick soon took on as a second task the armed protection of the pilgrims. This double function is expressed in the Order's motto *Tuitio fidei et obsequium pauperum*.

In 1113 the first statute of the Order was approved by Pope Paschal II

In 1291, with the fall of Acre, the Order was finally banished from the Holy Land. In 1309 it took its residence in Rhodes and it founded its first state From this time originates the still existing territorial sovereignty of the SMOM. The Order, which had spread in the meantime over the Christian Occident, gave itself a new organization which was composed of a division into 8 "Tongues", which again were subdivided into Priories and *Commendae*. While the task of the center in Rhodes consisted of the military defence of the West against the Turks, besides the care of the Hospital and the pilgrims, the work in the Priories and *Commandae* concentrated itself on the direction of hospices and schools.

In 1523 the Order had to capitulate to the superior force of the Turks and leave Rhodes. In 1530 it took its residence on the island of Malta. From this originates the current abbreviation of the name "Order of Malta." Malta held out in heavy attacks against the Turks until Napoleon occupied the island in 1798 and drove the Order out. Since 1834 the Order has maintained its central residence in Rome.

During its time on Malta the Order founded a medical and pharmacological university there, which gained a name especially in the fields of infectious diseases and maritime medicine. As the Order had lost nearly all its establishments during secularization, a new start was made in the second half of the last century, at first by taking over army medical services during wars. In 1864 the first new hospital was built by the Order in Flensburg in North Germany. Today, at the end of the 2nd millenium, the Order has reached an extensiveness as in its prime in the Middle Ages

The Order is represented by its own member organizations (Priories or Associations) in 33 countries in Europe as well as North and South America and in Lebanon, on the Philippines, and in Australia. The Order maintains full diplomatic relations and an exchange of diplomatic representatives with 53 countries The Order is a member or observer of many international organizations (UNESCO, WHO, etc.). Altogether medical and social help is provided in 90 countries throughout the world by entities of the Order.

Today the Order has about 10,000 members divided into 3 groups—professed knights, who make the promise of the three monastic vows as laymen; knights of obedience, who make a canonical binding promise of obedience; and the members of the third group, who without a canonical binding promise commit themselves to taking part in the works of the Order and leading an exemplary Christian life.

About 50,000 volunteers work permanently, mainly in the auxiliary organizations of the Order About 900,000 persons support the work of the Order by financial contributions.

The Order's Supreme Head is the Grand Master, who has the rank of a cardinal. He is assisted by the Order's government and the Sovereign Council

2. Health Care Activities

The management of the hospitals is the Order's oldest mission. The Order's work started with the establishment of the hospital in Jerusalem, and its name is still associated with it The erection of the hospital was at the beginning of the most important foundations of the Order in Rhodes and Malta, and hospital service became a regular part of the weekly service schedule of the members of the Order.

In 21 countries the Order possesses its own health institutions

The records show a total of 12 hospitals, 19 clinics, 32 dispensaries. The German Associations run 7 hospitals, 6 in Germany and one leper hospital in Thailand There is one hospital of the Italian Association in Rome, one of the British Association in London, one under the management of the French Association in Bethlehem, another hospital run by the French Association in Benin, and a leper hospital in Senegal under the responsibility of CIOMAL (Comité Executif International de l'Ordre de Malte pour l'Assistance aux Lepreux)

13 of the 19 clinics are situated in Lebanon, 8 of the 32 dispensaries in El Salvador In Italy the Order runs 16 dispensaries to advise and treat diabetic patients. The Australian Association runs a hospice for the terminally sick The Grand Magistery runs a blood bank in Malta

The management of the hospitals demands a high degree of professionalness This poses difficult demands for leadership Within the Church and as our duty within the Order we have assumed the task of healing given by the Lord What Christ fulfilled by virtue of his divine power we have to do by means of qualified medicine and care by well trained persons hoping in divine aid. Telling the story of the good Samaritan, Jesus deliberately stressed the competent help of the Samaritan It is not only the good will that matters, but also the obligation to acquire skill and to use it.

Ceremonia curativa huichol

The use of skill must be in accordance with the work of Jesus Christ aiming to remove the disorder and guilt brought into the world by sin. It is often quite difficult to find sufficiently competent personnel ready to completely share our Christian motives We must therefore run our institutions attentively and with personal commitment so that the staff will strive for qualification and realization of the Christian ideals which guarantee service to our Masters, the Sick, with attention to the whole person.

The activities in the field of hospitals are not restricted to the running of our facilities In New York, for instance, the Maltese participate intensely in the management of Catholic facilities in the diocese. In Australia they help in a very organized way to restructure the management of the Catholic hospitals of different orders as a consequence of the lack of new vocations

We should especially mention the activities in the countries menaced by civil war—El Salvador and Lebanon Owing to the will the work and the personal fortitude of the representatives of the Order, there has been an exemplary contribution to health care, which has been maintained under the most difficult conditions The principles of *obsequium pauperum* and *tuitio fidei* are realized in these countries as they were in the Middle Ages at the risk of one's life, yet without making use of the sword.

Furthermore, 18 entities of the Order have supported activities of other organizations in the field of health care. A great part of this support is given in the form of material aid like medicine and medical equipment

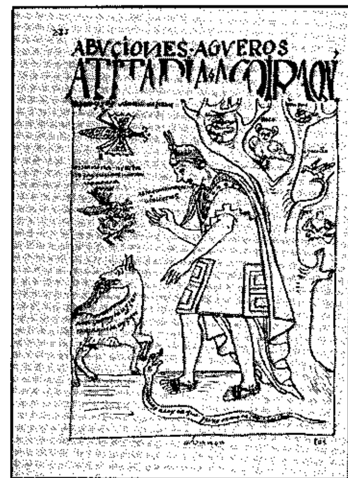
Care of the dying and the taking over of hospices for the terminally ill have become a new important task. Some steps in this direction have already been taken The Australian Maltese are running such a hospice; the London hospital has a hospice ward; and in the Maltese hospital in Bonn a small palliative station for pain treatment and the care of dying patients was inaugurated recently. The Californian Maltese take part actively in a hospice by means of voluntary services. In Germany further Maltese hospices will soon be opened For several reasons I hope that care for the dying will become an internationally unifying and characteristic task of the Order.

The reasons are the following:

— An ever smaller number of people can die at home, looked after by their loved ones

— Care for the dying is one of the few services suitable to become a symbol for the inviolable dignity of mankind and the sense of life

— The American Maltese in their typical, matter-of-fact manner call what is being asked from a Maltese "hands-on" care. The choice of their activities is, among other things, the result of the question whether this "hands-on" is possible, i.e whether the members can take an active part without having to acquire undue new knowledge. The running of the hospice is inconceivable without this approach.



Pronóstico médico inca

3. Social Services in In-Patient Institutions

The supplementary in-patient institutions of the Order are:

Altogether 6 old people's homes, 2 homes for handicapped, 2 workshops for handicapped, 4 kindergartens, and 3 institutions for refugees seeking political asylum.

In France the Order runs two homes for physically and mentally disabled young persons There are workshops for handicapped in Ireland.

The Order's growing commitment to the care of old people is best shown by the relatively recent take-over by the Order of six old people's homes—two in England, Germany, and Mexico, respectively Concern for the old will become an increasingly challenging task for the Order. By now about 35% of those over 65 in the wealthy countries are single—not considering the effect of the generation without children which is still to come.

In Germany the order runs three major institutions for refugees and those seeking political asylum

These stationary services are completed by a great number of mobile aids which are mostly given by the Order's relief organizations. They will be treated in detail in the next section.

Furthermore, especially the Californian and Mexican Associations give enormous financial support to numerous institutions of other organizations.

4. The Order's Voluntary Relief Organizations

The Order's relief organizations can be regarded as the most important activity. At present there are ten Associations, the biggest of which are in Germany, Ireland, and Austria, with others in Hungary, Switzerland, Italy, Luxembourg, and Portugal. The only relief organization outside Europe is in Paraguay There are more groups of volunteers starting to exist under the auspices of the Order in different places, as for example in Chile The most recent foundation took place some weeks ago in Rumania.

These organizations represent a relatively young activity within the Order, with which the Irish started about fifty years ago. The concept was originally oriented to first aid, medical services, and disaster relief. Social care and nursing services with the focus on old and handicapped persons are getting more and more predominant

The Order can enhance its field of activities with regard to first aid, disaster relief, and social services with the help of relief organizations in which the Order's members assume leading positions, while employing volunteers. In addition, the Order offers a great number of mainly young persons possibilities of action in accordance with their own social responsibility on the basis of Christian principles and with the greater possibilities of an organized association.

The foundation of such organizations is of great interest to the Central and East European countries liberated from communism. The bishops wish the formation of greater, more unlimited associations under the guidance of the Order, as during the communist regime there were no possibilities of forming lay structures, which are necessary for the church life in free societies.

Help and advice will be the major tasks for the newly forming initiatives of the Order in East Europe in the next years. Nobody could have imagined that the foundation of the Hungarian relief service two years ago would gain the importance it achieved in regard to the camp for East German refugees in Budapest and help for Rumania.

Recently an international working group of representatives of the relief organizations of the Order was founded and met for the first time in order to achieve coordination and efficiency in the field of international disaster relief.

The enormous involvement in Rumania at the end of last year was a first example for tests and successes in this sector. Organizations of the Order from seven countries were directly participating and others with donations. Organizations of the Order collected donations and material worth about $ 15-20 million and delivered them to Rumania

There was also great relief action for the Kurds in North Iraq which was financially supported by the German and Austrian governments as well as the EC, in addition to the medical service for young people on the occasion of the World Youth Meeting in Częstochowa, Poland on August 15th, 1991 which was carried out together with several national relief organizations of the Order

Other major activities in 1989 were medical care by the Malteser-Hilfsdienst of Germany for the UN observers in Central America; care for the 25,000 refugees from East Germany in Budapest, Hungary by MHD-Austria, MMSZ-Hungary, and MHD-Germany; the first aid service in St Peter's Square on the occasion of the great Papal masses and audiences, the medical service for 4,200 pilgrims to Fatima by the Portuguese Association; the medical service given by 1,300 helpers on the occasion of the German Roman Catholic Day, and the service for the procurement of medicine during the civil war in El Salvador.

The Order has nearly 27,000 voluntary helpers trained in first aid and disaster relief, 21,500 of these in Germany, 4,120 in Ireland

There are almost 1,000 ambulance vehicles, 204 mobile kitchens, 1 mobile field hospital, and further equipment, like gen-

erators, tents, busses, lorries, etc., most of them in Germany.

As already mentioned, the relief organizations also render services with regard to mobile social help. For 1989 this meant:

- About 3,000,000 people were transported with more than 340 special vehicles for handicapped;
- About 9,500 people took recourse to the service "meals on wheels;"
- In spite of illness and old age, more than 2,100 persons were able to stay at home, taking recourse to the "Emergency-Response-Service;"
- About 130,000 fugitives or refugees asking for political asylum were cared for;

(Most of these activities were accomplished by the German Malteser Hilfsdienst, other participants were Austria, Ireland, Scandinavia, Scotland, and Switzerland.)

- Three Associations organize holidays for disadvantaged and handicapped children;
- Quite a number of Associations participate in visiting services in hospitals or in homes;
- In The traditional "Christmas in April" organized by the American Associations, houses of poor people were renovated.

5. Work in Developing Countries and International Cooperation

The international character of the Order is one of its most significant features, influencing the history of Christian Europe. In modern times this international cooperation and support for developing countries have considerably increased.

The Order's support for developing countries started with help for lepers, which was established organisationally with the foundation of CIOMAL, an international organization of the Order, whose aim is the struggle against leprosy, with its headquarters in Geneva. It was mainly the work of the French Association, developing its different commitments in the former colonies and subsequently focusing on support for the developing countries—especially in Africa—establishing at a rather early stage a professional donation system with stress on help for lepers. The Americans followed with enormous material help. Other Associations are taking a growing interest in these tasks.

Support goes first to the Order's entities in the developing countries. Apart from supporting the poor, these relief activities are an important contribution to the organization of independent activities of the Order in the countries concerned. The Lord's message, "Go out into the world," is also addressed to us. We can give continuously, best of all in places where we are able to find members of the Order who will also engage themselves in spreading the Order's aims.

Furthermore, considerable support was given in 75 countries for the charitable activities of other organizations. More than 85% of this support comes from the French Association, who sent relief to 68 countries. 90% of this relief consisted of medicine and medical equipment.

A focus will remain on the struggle against leprosy. CIOMAL and the French Association are carrying through projects in many places, especially in Asia and Africa. In Senegal there is a training institution for doctors and nurses. The most renowned scientific magazine in French on leprosy is published by CIOMAL.

The list includes other basic health services, the battle against infectious diseases, training projects, as well as numerous socio-medical programmes—for instance, in Brazil.

6. Education and Formation

A great part of the Order's entities have their own training activities with stress on the paramedical field. By far the greatest amount of training was carried through by the German Malteser-Hilfsdienst.

215,000 persons received training in different degrees of first aid (210,000 in Germany, 4,800 in Austria). 5,360 persons received training or advanced training for service in emergency ambulances (4,840 in Germany, 520 in France). Nearly 20,000 persons were trained or received advanced training as assistant nurses; 195 nurses took part in courses (130 in Germany, 15 in Italy). Other fields of training comprised the elderly nursing (1,250 Germany), home nursing (2,000 in Germany), voluntary services in hospitals (3,000 in Italy); in Canada 1,500 persons were advised on the ethical problems of [sic] volunteers. Finally, 26 persons successfully took part in courses on leprosy relief treatment.

7. Pilgrimages for Sick and Handicapped Persons

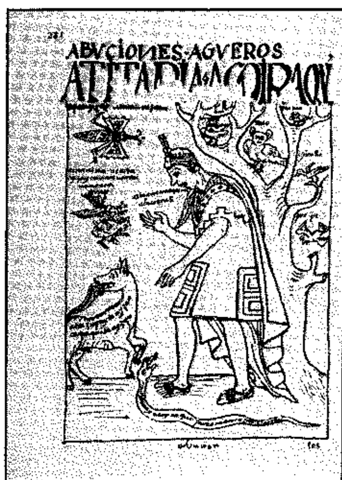
The pilgrimages for sick persons to Lourdes are of special importance to the Order. Many commitments go back to an involvement arising in Lourdes. The international Order's pilgrimage to Lourdes represents a unique chance to experience the internationality of the Order and to exchange experiences. Those who shared the hospital service in Lourdes have been able to experience the *proprium* of our Order in a place unequaled by others. The interconnection between *obsequium pauperum*

and *tuitio fidei* is directly manifested in this service, which accords with the Order's original tasks

17 entities of the Order carried out a total of 29 pilgrimages to Lourdes with 1,440 sick and handicapped persons and 2,450 helpers 29 additional pilgrimages for sick and handicapped persons to different places of pilgrimage were organized by 10 entities of the Order with 3,209 handicapped persons and 2,540 helpers.

In this connection we should also mention the international camp for handicapped youths in which 10 entities of the Order participated in recent years.

We have to be grateful that we have been able to increase our activities so much with the help of the Lord. In the future the SMOM will have to deal with further great challenges. The change in East Europe will bring new fields of activity during the next years, and there is no end in sight to the need of the developing countries. Again and again it is necessary—also for our Order—to keep in mind the demand of the Council for an up-to-date renewal in loyalty to tradition in order to fulfill our mission for the greater glory of God on earth, practicing Christian charity to embody Christ's message of healing in the world



Pronóstico médico inca

Elements for Developing a Health Ministry Program Within the Congregation

Introduction. Why a Health Program?

Different considerations have prompted the CSM-REPSA Health Commission to wonder about the appropriateness of proposing certain reference points for institutes as a basis for working out a health ministry program for these Congregations.

Some institutes already have orienting texts; others live out and seek to express this spirit or wish to work out a "program" which will give a meaning to the activity of the sisters engaged in health and social activity.

Situations change: the health world unceasingly evolves; the number of sisters decreases, and the average age of Congregations rises; there is *in loco* isolation of people and sometimes of the buildings themselves.

At the same time, other factors present themselves: Congregations' work in the course of recent general and provincial chapters on community projects; their questions in relation to the programs of the houses of the Congregation; diversity among projects; and the need to establish constructive dialogue among all those working in institutes

We discover from some of these considerations the reasons leading to the working out of a health program:

— To incarnate today apostolic religious life in the world of health This should be pursued specifically since it forms part of the living tradition of the institutes; it is a precious heritage, and history enables us to verify that social and health activities in themselves possess an apostolic value when performed through either institutions or individual involvement.

— To express values, the convictions at the root of our commitment and activities To communicate the reasons which have always prompted us to work in the world of health and still characterize our behavior.

— To offer Congregations some elements for examining their health programs so as to unify the policy each adopts in the different healthcare and social institutions they manage and program for the future

— To have, therefore, a more coherent line of action wherever we find dispersion and confusion.

— To identify the places where the commitment and testimony of religious are more effective. To be able, when the time comes, to pass the "witness" on to others under the most favorable conditions

— To place oneself in a state of faithful creativity in regard to the future.

1. A Vision of Man

A health program is a program for man this assumes that the concept of man underlying the program is defined.

1.1. *Man* is conceived as:

— a unique being worthy of respect;

— a free person responsible for his or her past and future;

— a person in a relationship to others and creation.

1.2. We propose to reach the *whole man*:

— To consider every person, of whatever age and life condition, in all his or her potentialities.

— To articulate all human dimensions: physical, psychic, intellectual, emotional, spiritual, and social.

— To seek to promote the harmony and unity of his existence bearing clearly in mind man's relation to his environment and his relations with nature.

1.3. We seek to reach *all men,* not just the individual, but also groups and populations, working together for the health of all and extending our efforts to developing countries as well These

objectives concern all men, regardless of color, culture, and religion, without exclusion or discrimination based on race or class. Our priorities include the marginalized, the excluded, and the poor.

This view of man incorporates two important demands of apostolic religious life:

— the welcoming and recognition of the poor, the smallest, those who are nearest;

— a universal conception sustained by the purpose of not retreating into our own "egoisms" as a rich country and the will to balance the effort made in France with the concern of the world's least favored populations. Health care ought not to be a good available only in some countries

Religious life is called to weld together these two demands as criteria for discernment, to verify the justice of intentions and actions for the advancement of man and social equity.

2. At the Service of Man

2.1. *What men* are we referring to? The defenseless, at whatever stage of life the child awaiting birth, the neonate, the sick, the disabled, the elderly, those in socially difficult situations, and the terminally ill.

2.2. *What service* is involved? To heal, prevent, educate, and accompany this service aims to promote the responsibility of persons, help them to be main actors in the reconstruction and maintenance of their patrimony in terms of "health", to develop their full potential in personal and social life

2.3 *What behavior is involved?* We are aware of the threats weighing upon defenseless man his body can become the object of experiments evaluated in purely economic terms; his freedom threatens to be manipulated, placed in a state of dependence by medical or paramedical power, the environment, and social organization; his existence may be blotted out or negated.

In the face of these threats, service to man demands an *ethics of life* and fitting behavior based upon the *values* to be defended, such as respect for the life of each human being, at all moments in his development and until his final breath, his freedom to choose how to act and decide in keeping with his convictions. All of this for each individual means:

— the right to express his demands, to be listened to, to receive replies taking into account his wishes and orienting him towards a better life;

— the right to be informed about his progress, according to the situation he is undergoing and his ability to manage it;

— the possibility of creating and maintaining bonds with the family, social, and cultural environment;

— a quality in relationships involving mutual recognition, help, and healing, where an attempt is made to reach a pre-established goal.

3. The World of Health

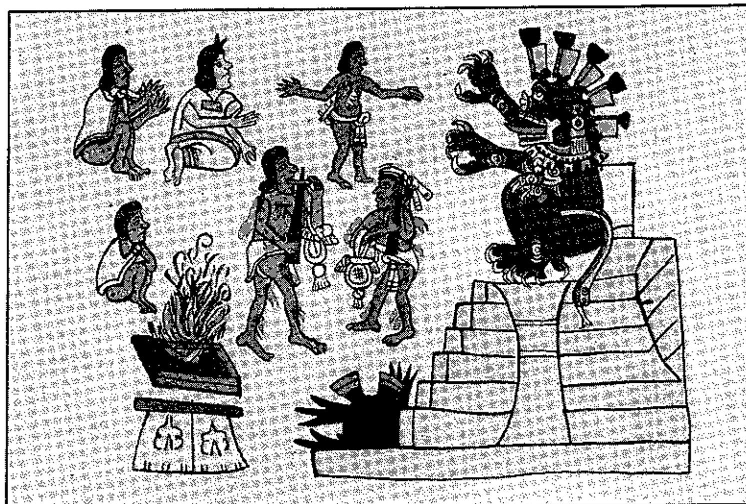
Committed by vocation to embodying the meaning of man in the world of health, we propose again to:

3.1. Work with others:

— for *collaboration* with those who individually and institutionally are in relation to us, in the different branches of health: the user, the family, professionals, administration, political leaders, and financiers (on this basis, no one has a monopoly);

— sharing or *participation* based on common convictions and established with persons and groups identifying with a core of values and prepared to promote them

Sharing and participation need means, though A program must be decided upon, whether already existing, in need of trans-



Ritual terapéutico azteca Códice Magliabecchi

formation, or still remaining to be elaborated.

3.2. *Take up our specific responsibilities in the health world*

It is a complex world, with burdensome structures, where health problems have multiple aspects: institutional, financial, technical, and administrative. We must acquire and develop appropriate competence. Ongoing formation and information are absolutely indispensable.

We must act upon different structural aspects of the "health sector," putting into practice the demands of human rights, justice, and ethics. In our society, public opinion and the mass media criticize health management. We must consider this fact and participate in the debate, which is particularly important for man's future. Associations and ethics committees always provide occasions for shaping moral thought in society.

4. On Our Mission as Church

The health program for man has value in itself. However, it takes on full significance if it is situated in the Church's pastoral activity in order to develop one of its fundamental aspects, service to suffering man, with whom Christ identified Himself (cf. *Mt* 25).

4.1. *The Church Today as the Mystery of Christ*

The mystery of Christ the Savior is expressed through gestures of healing and makes manifest the link between "healing" and "saving." The living tradition of the Church in its attention to the sick, poor, and excluded, prolongs and updates this Christian mystery associating healing and salvation. The charisms of our Congregations have at all times and today as well wished to incarnate the Church's concern for the suffering members of humanity, for they are the Body of Christ in his Paschal reality.

4.2. *The Church Is Present in the Struggle for Man*

Our society is permeated with conceptions giving the body, the most varied techniques, and "natural forces" themselves considerable importance for the maintenance of health and life.

What would seem far removed from a Christian conception of the body and its destiny can be the foundation for another revelation.

The Church, through Christian professionals and healthcare insti- tutions, must reach the points where men and women are searching for the meaning of life, health, and death. Religious women have, by vocation, the mission of making the Church present among marginalized people and populations, according to the charism of their Congregations. In this perspective the health ministry program brings out an important dimension of the mystery of the Incarnation: "The Word was made flesh..., [and] experienced our human condition..., to the point of death... and glory."

4.3. *The Church in the Health Ministry*

This ministry gathers together all those in the Church working in the social and health areas. An ethical process requires the confrontation of all participants in movements for Catholic action and Christian professional associations. Together, starting from an analysis of personal and social behavior, they can release those values which direct Christian action and give meaning to the destiny of the human being. Communication within the health ministry is enriched in openness and sharing with other areas of Church life, particularly those basing their work on solidarity. The Congregations carrying out the same apostolic task in this sector of the Church for the good of the whole world must increasingly concert their action and relations with Christian movements and/or associations, to make their work more up-to-date.

The health program is a means through which the charity animating Institutes and the Church incites them to discover new forms of intervention benefiting wounded man in our time.

IMPLEMENTATION OF THE HEALTH MINISTRY PROGRAM WITHIN THE CONGREGATION

One single apostolic purpose underlies the elaboration of the Congregation's health ministry program and its implementation, whether carried out inside an institution or through individual involvement This implementation is based on belonging to a Body to which the Church has entrusted a mission effected as an act of sending

A) Inside an Institution

Implementation inside an institution, in the name of Christian values, still conserves its current relevance in a pluralistic society. The health ministry program of a Congregation is called to take on concrete form particularly through a project fixing certain tasks. An institutional presence in the health and social field is important in a dynamic incorporating:

— the evolution of structures;
— the closing of some sectors;
— the creation of new services

This implies constant evaluation of the requests for aid and care and a selection of the instruments to effect the needed choices

The management of institutions depends on social and ecclesial cooperation precisely corresponding to the preceding points (cf 3.1 and 4.3)

B) Individual Involvement

A Congregation's health ministry program is carried out equally by the individual involvement of its members in the institutes and/or services not managed by the institute itself.

This type of presence, based on the sending of each individual, often permits greater closeness to those living on the fringes of the Church—that is, greater apostolic mobility

These two modes of carrying out the program—institutional and individual—for pastoral care in health on a congregational level are complementary, and both witness to the community dimension of involvement by religious in the world of health.

THE CSM-REPSA
HEALTH COMMISSION

Pharmacopoeia and African Traditional Medicine: A Twelve-Year Road

Some scientific research conducted successively between 1952 and 1982 in different fields—such as plant biology, soil microbiology, mycobacteria, the bacteriology of leprosy, and the study of plants against leprosy—have confirmed themselves (without our realizing) to be a long road towards a new world, a different knowledge, an unimaginable medical art.

We would never have imagined that the doors of African medicine would one day open to us, that topflight masters would receive us and accord us their confidence, enabling us to share in their knowledge, and that in 1980 with their help a modest leprosy treatment center located twenty-five kilometers from Dakar would appear.

This center, after a hard start, went on to develop, thanks to the contributions of charitable action, until becoming the Keur Massar Traditional Hospital in 1985

1. The Founding of the Treatment Center

The bacteriological research on *Mycobacterium leprae* begun in 1969 brought us into contact with the sick The appearance of mutilated patients, those with plantar-perforating wounds that never healed, with painful, persistent neurites, subject to serious and often hard-to-control leprous crises—all of this demonstrates how imperfect and frequently harmful the action of sulphones and sulphamides was. An idea gradually established itself: the need to find an alternate solution, another way to study the treatment of leprosy.

Some studies on anti-leprosy plants in Senegal's traditional pharmacopoeia conducted between 1976 and 1979 brought out marked antibiotic activity on numerous pathogenic microorganisms, but particularly on the new Mycobacterium, which we in due course isolated in a special environment, starting from pathological products of leprosy (cutaneous biopsies, serums, urine)—a whole set of factors led us to think *Mycobacterium leprae* was involved.

These experimental results encouraged us to continue, though we did not conceal a certain hesitation in turning to therapeutists traditionally known for the treatment of leprosy.

As a European, I had no chance to get in touch with them, but the intervention of a man of providence, Yoro Ba, who became our first co-worker, notably facilitated things for us. Coming from a noble Peul family and fully incorporated into traditional circles, he was able to establish privileged relationships—first with a great master of his ethnic group, Dadi Diallo, and then with masters with other ethic origins (Socé, Sérère, Toucouleur, and Bambara) A man of faith, prayer, and inexhaustible charity, Yoro Ba was to give himself entirely to the sick until the day God called him to his side in 1989.

2. The Teaching of African Medicine

Teaching—or, if one prefers, school—begins in the savanna with departure at dawn to gather medicinal plants. The master speaks only when he deems it necessary. When people come back, the plants are left to dry. Later the pharmaceutical phase is entered upon the preparations for medicines to be administered internally and externally are numberless

Knowledge of the virtues of medicinal plants and of the composition of medicines reaches a degree of precision and perfection which a western mind cannot imagine. We are asked how such knowledge may have been acquired. The matter remains a mystery for us.

Clinical teaching is provided by contact with patients; the student is always close to the teacher

3. Characteristics of African Medicine

It is very difficult to penetrate into another culture and practically impossible to comprehend it in depth In spite of this, many aspects are confirmed to be accessible to a mind that is open to receive them

African medicine has always been a synonym in Europe for witchcraft, strange practices, superstition, and incomprehensible amulets, so that its effectiveness is seriously doubted. Ideas on the subject are beginning to change, but there is still a lot to do before it is recognized for its full value.

African medicine, like all forms of medicine with a tradition behind them, maintains a sacred character, whether practiced by Moslems or animists The therapeutist is the intermediary between the divinity and the patient; he provides care, but it is in reality God who heals.

There are two worlds here, visible and invisible, in relationship to each other, and wicked or offended spirits may attack man and provoke diseases, particularly mental disturbances.

Man belongs to the cosmos, and the other living creatures, animal and vegetable, also created by God, people the earth and are worthy of respect The behavior of therapeutists towards plants is imbued with this worldview.

Before beginning to gather plants, an interior greeting is addressed to them, and sometimes offerings are left in compensation for the roots and other parts of the plant which are removed. The preparation of medicines is an important act, carried out with great rigor The "incantations" or recitation of verses which surprise Europeans, too unfamiliar with the sacred, are nothing but prayers whose purpose is to attract divine blessings upon the medicines so that they will contribute the greatest possible benefit to those using them.

Another aspect deserves to be mentioned: the person preparing the medicines, during the action of preparation, must have his soul at peace. Wrath, irritability, and aversion force him to put off the operation until he recovers calmness.

The approach to the sick is above all that of sacred medicine. The patient is again placed in relation to the visible and invisible world, but, like all forms of medicine, this one is also based on quite concrete facts which are the phases common to all who practice it

The patient is questioned:

— The queries reveal the refinement of clinical knowledge.

— Detailed examination of the face and hands, which provide indications unknown to European medicine.

— Palpation is characterized by repeatedly taking one's pulse and by movements and maneuvers quite different from ours.

— Percussion is seldom practiced.

— Auscultation is performed with the naked ear.

African medicine also uses a certain number of "analyses" carried out through recourse to different plants and minerals.

Another aspect of medical activities is the art of divination, but it is practiced only by therapeutists specializing in psychiatric illnesses and not very serious psychic disturbances.

The beginning and end of the medical examination are sometimes accompanied by a prayer, while the therapeutist holds the patient's head in his hands. This act brings the patient relaxation and a sensation of well-being

4. The Experience Acquired among Leprosy Victims

Leprosy has always created major difficulties for treatment. This characteristic involves the prolonged incubation period, the clinical forms, the extent and variety of lesions, and biological and psychic disorders.

In addition, the bacteriology of leprosy poses a problem which reasoning has not brought out clearly, but which ought to be emphasized. Lepromatose leprosy involves the massive invasion of the cutaneous vestiture by *Mycobacterium leprae* and its presence in the blood and internal organs Such a high bacterial density makes the infection's seriousness understandable.

On the other hand, tubercular leprosy, known as "abacillary" or "paucibacillary," often causes serious, extensive lesions which the reduced number of bacilli identified does not enable us to explain: this enigma deserved in-depth research The experiments carried out have demonstrated that *Mycobacterium leprae* and the other mycobacteria have a complex biological cycle, one of whose stages is effected through filterable forms discovered only by the electronic microscope and capable, when placed in appropriate conditions, of evolving towards the classic acid-resistant bacillus. These elements are elaborated by the bacilli and released with cell lysis. An important phenomenon follows: anti-leprosy medicines may destroy the bacilli without, however, altering the filterable forms contained in them. These, once free, ensure the maintenance of pathogenic elements in the patient's organism and provoke the relapses which are sadly familiar It is in the awareness of all these difficulties that we have dealt with the treatment of leprosy according to the knowledge of African traditional medicine.

African medicine has a variety of therapies for leprosy infection. The treatments are adapted to all forms of leprosy, all states of evolution, and all lesions. There are also specific therapies for pregnant women and children and preventive care to which the children of leprosy victims must submit themselves. We have indeed verified *in vitro* that certain plants destroy the leprosy Mycobacterium, isolated in our laboratory together with the filterable forms.

Care follows successive stages:

— Initial treatment involves a preparation designed to eliminate toxins encumbering the organism.

— Basic treatment consists of numerous preparations which are periodically changed.

— Final treatment is based on special plants prescribed in specific doses.

Therapy is applied by both internal and external routes, for the varied preparations have highly differentiated aims:

1) anti-mycobacterial preparations and

2) specific preparations for the following pathologies:

cutaneous maculas
damage to sensitivity lepromas
ulcers shiny, rough, and cracked skin
plantar-perforating
wounds adenitis
bone lesions
edema ophthalmias
neuritis
rhinitis paralysis
laryngitis
paresthesia
abdominal pains
psychic disturbances

When the patient turns to the doctor in time, it is also possible to prevent mutilations

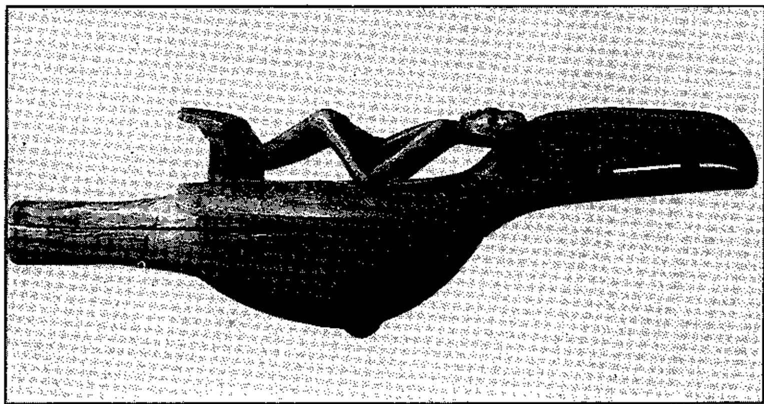
Thirdly, there are diuretic and tonic preparations and those stimulating the organism's defenses.

Exceptions aside, properly followed treatments do not lead to leprous reactions. These may occur in the oldest and weakest patients, who are subjected to greatly reduced doses. But such reactions are controlled immediately, thanks to special substances. All of these medicines are in the form of decoctions, infusions, steeps, powders, creams, antiseptics, eyewashes, mixtures for inhalations, and baths for hands, feet, and complete ablutions The main characteristic of the medicines we have spoken about is the high degree of elaboration of the substances themselves and of leprosy treatment. Not only is the destruction of the bacillus proposed, but there is care of all lesions to be found in the organism and the psyche of patients It must also be recalled that care based on these principles varies from region to region according to the resources of local vegetation. What we have observed in Senegal is valid for all other African countries. We can imagine the patrimony of knowledge this continent —which we always tend to regard as devoid of knowledge— has accumulated over the centuries Finally, a last important point must be indicated The therapeutists in question maintain that the care of leprosy has for some years now become more difficult, for its clinical manifestations tend to be modified. The cause probably lies in a selection in the stock of *Mycobacterium leprae*

The sulphones prescribed in monotherapy have provoked the appearance of different resistances; an identical phenomenon is now being repeated with Rifampicina. Gradually only the most virulent germs will remain which have withstood the attacks of mono- and then polychemotherapy. In the face of these facts the physicians of Keur Massar and other great masters specializing in leprosy seek to organize the defenses needed for the new situation

5. The Experience Acquired in General Medicine

External examinations involve patients with the most varied pathologies: respiratory diseases, asthma, tuberculosis, cardiovascular illnesses, infections of the digestive apparatus, gastritis, ulcers, intestinal disturbances, urinary, gynecological, and sexually transmitted diseases, nervous ailments, epilepsy, mental disturbances, and, in addition, dermatosis, diabetes, rheumatisms, viral hepatitis, cirrhosis, malaria, parasitosis, depranocitosis, and so on.



For each of these diseases afflicting the human being we propose care which, if properly provided, leads to highly satisfactory results. The best proof is given by the fact that since 1985, in spite of the distance from the large cities and the difficulties in local transportation, a considerable number of patients have come to be examined at our hospital

The treatment of illnesses in general implies vast knowledge of the use of plants and their administration. On our part, the hard school of leprosy, in addition to providing us with experience in the other sectors of pathology, has enabled us to acquire the necessary bases to deal with the new situation created

by the appearance of AIDS with courage and hope.

6. AIDS

In 1987 we received the first patients affected by the virus who required our help. It was not possible to send them away empty-handed, in that state of anguish and despair. We consulted each other on how to organize treatment adequate to that singular disease. We explained to our co-workers that the pathogenic agent belonged to the same "family" as those causing infections such as measles, mumps, hepatitis, poliomyelitis, influenza, aphtha, and warts. This indeed permitted the establishment of an inventory of antiviral plants. We then focused the clinical facts of the illness better: fever, loss of weight, weariness, adenopathies, itching, dermatosis, paresthesia, arthralgia, etc. and the entry of numerous pathogenic agents causing other diseases. On this basis therapeutic research has become engaged, and many hours of work and reflection have been needed. The first care provided offered promising results; experience then enabled us to improve, broaden discoveries, and prepare a diversified range of medicines. Research has, therefore, not ceased; new therapeutic systems may reveal themselves to be even more effective. The general principles of treatment are as follows:

— first of all, to combat the patient's anguish with suitable substances;
— to counterattack the virus;
— to impede the invasion of other pathogenic agents or the revival of germs already present in the organism;
— to follow the signs, symptoms, and lesions;
— to tone up the organism and clear it of toxins.

The administration of the medicines available to us can obtain different effects simultaneously, even when some of them have a specific function.

Their properties are as follows: antiviral, antibacterial, antimycobacterial, antimycetal, and antiparasitary. They act, above all, on symptoms such as fever, weariness, weight loss, adenopathies, arthralgias, itching, dermatoses, paresthesias, diarrhea, gynecological disturbances, anaemia, and psychological disorders.

We also ought to mention their diuretical, anti-allergy, and tonic value. The substances are intended for asymptomatic seropositive patients at the primary or intermediate stage of the illness (including the development of tuberculosis). AIDS cases without any more defenses, with tumoral complications and infections, are in a phase of the disease for which it is more reasonable to hope in a new therapy. All that can be done is to seek to reduce patients' sufferings. In the course of the last five years the treatments prescribed have not provoked any incident; patients have immediately observed an improvement and have seen symptoms attenuated. Our work conditions are not ideal; the socioeconomic reality of the population quite often puts periodic testing and analysis out of reach, but in two fortunate cases the tests carried out have shown a return to seronegativity. These patients, who seemed to be the hardest hit, had pulmonary tuberculosis.

A light of hope has appeared, then, in the tragic field of AIDS.

African traditional medicine would be able to play an important role in the fight against AIDS, but a similar path could be followed in Europe as well by returning to ancient knowledge and resorting to plant medicine.

Some of the treatments prepared according to the general principles set forth above would undoubtedly reveal themselves to be effective in the less desperate stages of the disease. The first tests carried out in Europe with plants have been seen to be promising. We expect chemistry to discover new molecules in a world unknown to us, but it would be wiser to have recourse at the same time to the whole therapeutic patrimony of mankind, a real treasure too often discarded with excessive haste. The plants, creatures of God, have uninterruptedly produced innumerable immediately available substances. They ought to be our best allies in the fight against AIDS.

7. Conclusions

The experience of twelve years lived in contact with the great masters of African medicine has enabled us to discover the wealth of the countries we regard as backward. It is our hope that our work will enable us to approach the cultures and peoples with respect for their dignity. Europe has given much, but it also has much to receive, whereas Africa has received just as much, but still has a great deal to give. This awareness would permit us to contribute new solutions to the health problems of our time.

8. Acknowledgements

We render homage to the memory of Yoro Ba and express our gratitude to Dadi Diallo and the physicians who have opened the doors of their knowledge to us.

We thank the charitable institutions that have made our efforts possible in an unexplored and unusual field:

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Finally, we thank the Werk der Hl. Kindheit e.V. Aachen, for help in caring for children.

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Doctor in Science and Medicine, Director of the Traditional Hospital of Keur Massar. Senegal

Activity of the Pontifical Council

Diagnóstico de la enfermedad Códice Tudela

Talks

Chronicles

Care of the Dying

A Subject of Central Concern for the Health Ministry Today

An address by Cardinal Fiorenzo Angelini at the International Conference on the Care of the Dying organized by the Center for Bioethics at the Catholic University of the Sacred Heart, Rome, March 15-18, 1992.

Every reflection on death and on care of the dying as well necessarily starts from a specific vision of life. For the health ministry, care of the dying must first of all be inspired by the Christian conception of life, which changes with death, but is not erased (*mutatur, non tollitur*), as we are reminded by the liturgy for the dead.

Moreover, in the Gospels the concept of eternal life does not embrace only the heavenly phase of human existence, but also the earthly one, according to the words of Christ: "I have come so that they may have life and have it in abundance."[1] And the fourth Evangelist also affirms, "This is eternal life, that we believe in Christ," the Son and Word of God,[2] for "whoever receives the Word" of Jesus "has eternal life."[3]

The Gospels narrate three miracles worked by Christ in raising people from the dead: the resurrection of the son of the widow of Naim,[4] the resurrection of the daughter of Jairus,[5] and the resurrection of Lazarus.[6]

To the widow of Naim accompanying her son to the tomb Jesus says, "Do not weep!"[7] When arriving at the house of the head of the synagogue, whose young daughter has died, Jesus says, "The girl is not dead, but is sleeping."[8] Concerning Lazarus, whom he knows to be already dead, the Lord assures, "Lazarus, our friend, has fallen asleep, but I am going to wake him up."[9] And the fact that the Lord did not intend to speak metaphorically about death is confirmed by the disciples' reaction: "Lord, if he is sleeping, he will be well." But Lazarus had already been dead and buried for several days.

The Christian dimension of death is life. A dimension assimilated by all religions and by the pagan world itself, if the poet affirmed: *Non omnis moriar* ("I know that I shall not die completely").[10] St Paul summarizes this truth laden with mystery and hope in the words: "For none of us lives for himself and none of us dies for himself. If we live, we live for the Lord; if we die, we die for the Lord; whether we live or die, then, we belong to the Lord."[11]

This global vision of life and death, if transferred to the condition of those inexorably approaching death or about to die, takes on the most varied aspects, becoming a mirror of the individual reality of each human person. Indeed, Seneca wrote, *Nihil melius aeterna lex fecit, quam quod unum introitum nobis ad vitam dedit, exitus multos* ("The eternal law did nothing better than give us a single way to come into the world and many ways to depart from it").[12]

As there are no illnesses, but sick people, so there is no category of the dying, but each individual human being experiences in a most personal and unrepeatable manner the mystery of the passing from the provisional dwelling on earth to the one St Augustine called "the fatherland." Over a monumental chapel in the cemetery of Staglieno in Genoa, we read in large letters the text "The hour has chimed to go back home."

This is a universal sentiment which the different religions have expressed in the most varied ways, which nevertheless share an intimate awareness that with physical death[13] man's life is not extinguished forever.

I have been asked to offer some reflections on the subject of care of the dying in the perspective of an up-to-date health ministry. Let me say that I would prefer the adjective "rediscovered" to "up-to-date."

The health ministry, in care of the dying, is in fact illuminated, in a Christian dimension, by the resurrection of Christ, who, in overturning the burial stone at his tomb, became "the first fruits of those who die,"[14] to the point that "if Christ did not rise again," our faith is without foundation, and "if we have placed our hope in Christ for this life alone, we are the most wretched of all men."[15]

This was the thought and this was the faith of the nascent Church; to "update" both in care of the dying simply means to recover these values.

Personally, I shall never thank the Lord enough for having obtained, in the course of the Second Vatican Council, the acceptance of my proposal for the renewal of the rite of the Anointing of the Sick, with the elimination of the phrase "Extreme Unction," authorization to confer the Sacrament even before very serious operations, the reduction to just two anointings of the sick person (on the forehead and the hands to signify thought and action), and the introduction of appropriate elements to prepare administration of the Sacrament and celebrate it.[16]

The spirit of liturgical renewal in administering the Anointing of the Sick was and remains that flowing from a basic consideration which I shall never tire of repeating: religious assistance or, properly speaking, the health care ministry, is not something

independent, separate, subrogating, or merely additional with respect to general care of the sick. It is an integral part of care for all the sick without any distinction.[17]

What can and must differ in the realm of the health ministry is not its nature, but its way of expressing itself and being exercised. That is, it must take into account those it is directly or indirectly aimed at, none of whom must be overlooked or ignored by it. Only in this fashion does the health ministry fall within the concept of evangelization, in keeping with its prerogative.

I love to call the hospital "the most frequented temple in the world," precisely because all those admitted to it or working therein represent to an eminent degree a human community with an essential need for spiritual assistance The place of hospitalization and care is a decisive moment for man's existence: it is such for the sick, faced with the most arduous trial of their lives, and also for health professionals, extending from administration to therapy and direct care, who experience the fact that their profession is a mission, too.[18]

There is too much superficial talk of hospitals and clinics as facilities, almost as if accentuating their material, operative, and technical dimension. Tradition prefers the term health care "institution," as if to indicate a whole, a *moment in human experience*, a real *existential situation.*

The consequences to be drawn from these presuppositions, which I deem indispensable, are multiple, but I would like to stress three of them, which I regard as priorities in regard to pastoral care of the dying: 1) to avoid their isolation, 2) to involve family members and friends and health personnel, and 3) to prepare for death under the sign of religious hope

1. To Avoid the Isolation of the Dying

Whoever frequents hospital wards, even as an outsider (I am not referring to specific wards for terminal patients, which are, moreover, rather unusual), immediately receives some painful impressions which often verge on becoming chilling.

Everyone, patients and visitors, knows everything about everyone, and in their speech, movements, gestures, and observations one notices a classification of evaluations which frequently, in a low voice or by signs, translate into substantially offensive—when not outright jinx-like—manifestations: "His time has come!" "They're treating him now just to take away pain!" "He had a crisis tonight and seemed to be on his way out." "It' just a question of hours now." "Poor fellow, his trials are ending." And so on.

With hospital staff a phenomenon occurs which is singular, to say the least: while care is not lacking at the bedside of those who could wait, there is a standstill by the beds of the dying, and relatives are forced to call, often to no avail, health personnel that comes reluctantly and fleetingly. And there are numberless relatives who, to ensure care which is falsely deemed optional, offer deep-felt compensation to paramedics who thereby transform a deontological duty of theirs into a favor, forcing the beneficiary to interpret the obtaining of a right as a benevolent concession.

Psychological isolation, moreover, also takes on the aspect of a progressive lying to the patient, who, even if not prepared to receive the complete truth about his condition, can never be regarded as the victim designate of a not very convincing lie.

Pronóstico de la enfermedad Códice Magliabecchi

Medical science has been maintaining for some time that there are no untreatable maladies, only incurable ones, and in any event therapy can always be implemented which, in acting upon the patient's psyche, constructively cares for his state of depression, sometimes obtaining unexpected results on a strictly therapeutic level as well.

In reality, the "flight" of physicians and paramedics from the dying also depends on the professional deformation by virtue of which the primary aim of health care is thought to be the cure of the sick alone.[19] That is not so. And the Master Cesare Frugoni repeated to his students, "Remember that if one cannot always cure and treat, one must always console." [20]

A health ministry for the dying, whether exercised by priests, men and women religious, or committed lay people, which does not work to avoid the progressive isolation of the sick lays the foundations for failing in its intent.

We may be asked, But how can we act to avoid this isolation? Experience has taught me a fundamental truth: The patient himself, as his condition worsens, nearly always manifests implicitly but quite clearly his growing need for communication, dialogue, and "company"; and he does so by often agonizing, but always eloquent nuances.

In a word, those responsible for the health ministry must not be sought out by the patient, but should always let themselves be found by him. When I repeat that I have received much more from the sick than I have been able to give them, I am confessing a long-experienced truth, especially because the bed of the dying is the loftiest teaching chair of life.

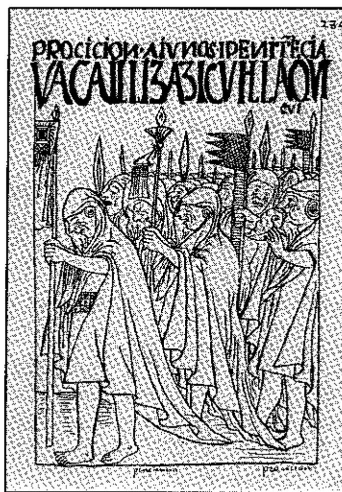
2. Involvement of Relatives, Friends, Health Personnel, and Volunteers

In speaking of "flight" from the dying, I did not want to formulate an accusation, but make an observation. The phenomenon depends to a great extent on a lack of basic training which must be urgently made up for.

It is useless to repeat that the health ministry is an essential component of pastoral care as a whole and then consider it in terms of concrete action as an utterly separate, peculiar sector. People are trained for the health ministry as they are trained for the ministry in general.

The involvement of relatives and friends in care for the dying is a deontological duty of pastoral workers in the health field, but also of doctors and paramedical staff and, I would say, of the administrators themselves of these institutions. The members of the health care team must never forget that the patient "is a human being whose personality should be studied, whose fears and concerns should be comprehended, and whose morale, in facing illness and all that it means for him, must be sustained." [21] In order for the patient to be able to prepare for death, those surrounding him must help him to prepare for death.

I was told about a young doctor at a Roman hospital, esteemed and loved by all who know him, who with great simplicity and conviction is able to remain alongside the dying as a



Ritual inca para ahuyentar las enfermedades

health professional and pastoral worker at the same time.

Seated beside the sick, without any rush, but attentive and solicitous as if he had nothing else to do, after having taken care of the therapy decided upon, he is accustomed to taking them by the hand affectionately and saying, "Now that I have done my part, let us try to say a prayer to Him who can do much more than I!" This fine doctor does not hesitate to act that way even if the patient professes a religion other than Christianity or has previously declared himself to be a nonbeliever. In one way or another, with this words or others, he is concerned about reaching the heart of the dying, touching their deepest emotions.

I am convinced that every doctor well knows what the dying are seeking and what they really need. No one better than the health worker can identify with the terminal patient's situation. Why does he hesitate to do so? Why does he let himself be conditioned by routine, which is the real negation of care for the suffering?

To attempt to respond to these questions is already to make a choice in keeping with the authentic health ministry.

However, it should be recognized that the expansion of health care, the astronomical increase in the dying receiving medical attention requires complete support which can be only partially guaranteed by volunteers. And not this alone, but seriousness, globalness, and continuity in care need organizational instruments.

The growth, especially in Europe and North America, of so-called *palliative care* or *support groups* for terminal patients [22] confirms an increased sensitivity and concrete response to the problem of care for the dying. This care, which obviously excludes the possible negative meaning of the term "palliative," must occupy an important place in the health ministry.

3. Preparing for Death Under the Sign of Religious Hope

While we say we believe that the sacraments are the true channels of the grace of God, we in fact disregard their extraordinary function in psychological and spiritual therapy.

The sacraments of Penance, the Eucharist, and the Anointing of the Sick are the central moment in the health ministry.

Alongside the dying, I have often thought—as regards the Eucharist—of Jesus' words when He announced the institution of this sacrament: "Whoever eats my flesh and drinks my blood has eternal life.... For my flesh is real food, and my blood real drink." [23]

The pastoral worker in the health field is a mediator of these extraordinary instruments of grace: he can spur the dying towards a real conversion of the heart; he can nourish them with the body and blood of Christ; he can sustain them with the Anointing of the Sick, whose ce-

lebration is often a synthesis of the sacramental triad.

Unfortunately, statistics speak of a small number of dying people who turn to this gift of grace. But how often this occurs because of the inertia of pastoral workers, because of a lack of preparation for this decisive step, because of insufficient cooperation by the main actors in events transpiring at the side of the dying. And the same must be said, though in a different context, for the dying of other religions or so-called nonbelievers. There is, however, no lack of exceptions, those who, with their recognized exemplariness, represent a real call to the vanguard in the care of the terminally ill

About a month ago, having organized in New York an extraordinary meeting of the Catholic hospitals in the United States and Canada, I wanted the sessions to conclude at *Calvary Hospital*, an institution owned by the Archdiocese of New York with two hundred beds reserved exclusively for terminal cancer patients who have their own rooms at the hospital. I had already visited this hospital the year before with special attention, remaining spiritually impressed, particularly after having met its exceptional hosts Let it not appear to be exaggeration dictated by emotional emphasis, but I would like to say that it would really be worthwhile to go to New York just to visit Calvary Hospital The observant visitor is immediately struck by the propriety, distinction, style, and industriousness which are so markedly humane and humanizing, the serenity, participation, solidarity, sharing, love for all regarding each as onès brother or sister, even the other person professes a religion other than Christianity or is a declared nonbeliever. In this hospital mortality reaches 600 people a year, with an average of two deaths a day. There are always patients who for a certain period can return to their families and then come back to the hospital. The involvement of relatives in care is, indeed, seen to in every possible way.

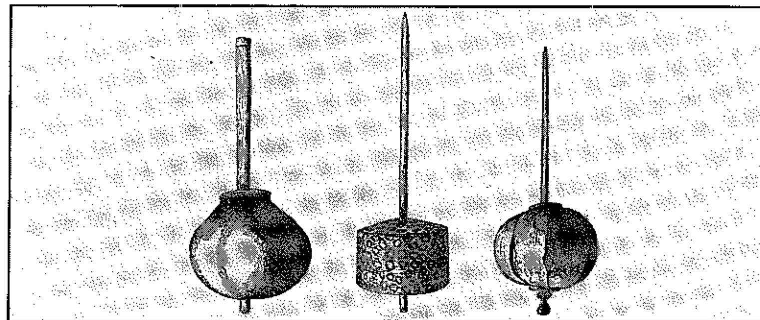
Doctors, nurses, religious, lay people, and volunteers work with total dedication; they know that none of those they help will ever thank them for getting cured. The necessary and proper multidisciplinary approach is not an abstract hypothesis or a theoretical attempt, but an existential reality.

At Calvary Hospital deeds affirm that the sick are always treatable, even if, from a human and scientific standpoint, incurable. There is concrete demonstration that the object of attention and care is the person, in his material and spiritual integrity, not, indeed, illness. Help is believed to reach the spirit directly, where people can be real athletes, even though the body is collapsing And death? As I recalled, *vita mutatur, non tollitur*.

the following expression: in comprehension and communion, man does not cease to feel like a person, even if he knows he is crossing the threshold of death

Never as in the decisive moments of life does man perceive the need to feel around him the community to which he belongs, whether family, social group, or, for the believer, more specifically, the Church. It is this community which must be made aware, prepared, and called together to be close to the brother or sister about to abandon earthly life.

I have known terminal patients who, when they were healthy, neglected their religious duties, but who, when approached with affectionate solicitude as they were drawing near to death, had already carried out, in the depth of their hearts, a radical change. Several times, with astonishment, I have received this confession or confidence: "You know, Father, I have prepared myself to die; now I feel a great peace within me"



Sonajeros de médicos tarahumaras

At Calvary Hospital we realize that these concepts and these very sensations are not a utopia, a dream, or sentimentalism, but that they are rooted in the true conception of human pain, of its constructive value, and of its transcendence. It is the real capacity to be able to live with those leaving life; it is the limpid, inexhaustible strength to reject the risk of becoming habituated to the suffering and death of others; it is the intelligence to understand life and love it at the teaching chair of death; it is the awareness that the hospital is the temple of all and that its aims are sacred. Certainly, every hospital is a "Calvary," but in this dimension, it is Calvary which preludes and prepares for the Resurrection.

The experience of Calvary Hospital may be summarized in

We must rediscover the courage to recognize that, in the most delicate task of assisting the dying spiritually, the truest, most incisive, and deepest pastoral work is carried out by the Lord, with the mediation of his Most Blessed Mother We are simply called to be instruments of this divine action and must realize the full, serious responsibility for being suitable instruments for the action of grace.

The "updating" of the health ministry is not arbitrary innova-

tion, but the rediscovery and recovery of Jesus' own sensitivity to the suffering. When visiting the Nirmal Hriday Ashram in Calcutta on February 3, 1986, John Paul II, alongside the dying taken in by the daughters of Mother Teresa of Calcutta, called that hospital "a place of hope, a house built on courage and faith, a house where love reigns, a home overflowing with love." And after having formulated the clearly spontaneous questions of the dying on the reason for human pain, the Pope said, "I cannot respond fully to your questions; I cannot take away all of your pain. But I am sure of this: God loves you with an infinite love. You are precious in his eyes. In Him I, too, love you. For in God we are truly brothers and sisters."[24]

This is the place, the dimension of the health ministry, especially in care of the dying: to transform healthcare institutions into homes overflowing with love.

[1] *Jn* 10:10.
[2] *Jn* 3:34
[3] *Jn* 5:24.
[4] *Lk* 7:11-17.
[5] *Mk* 5:31-43
[6] *Jn* 11.
[7] *Lk* 7:13.
[8] *Mk* 5:40.
[9] *Jn* 11:11
[10] Horace, *Carmina*, III, 30, 6
[11] *Rm* 14:7-8
[12] Seneca, *Epistolae*, 7, 14.
[13] I am speaking of "physical" death in a very general sense, without going into the question of the exact definition of death and its verification. In reality, as the document approved on February 15, 1991 in Italy by the National Bioethics Committee, chaired by Senator Adriano Bompiani, recognizes, "in practice, it may be said that death comes when the organism ceases to be a whole, while the process of dying ends when the entire organism has reached complete necrosis." Cf. "Definizione e accertamento della morte dell'uomo. Conclusioni generali e pareri del Comitato Nazionale per la Bioetica," in *ISIS News* (a Monthly on Public Health), 6 (March 1991), 9. In other words, only life makes the organism "a whole."
[14] *1 Co* 15:20.
[15] *Ibid.*, 15:18-19
[16] For my words at the Council, cf. *Il Concilio Vaticano II. Cronache del Concilio Vaticano II*, published by *La Civiltà Cattolica*, edited by Giovanni Caprile, SJ. Il primo periodo (1962-1963), II (Rome: Civiltà Cattolica, 1968), 122. The author goes back to the *Acta Synodalia*.
[17] "There is a necessary interaction between the practice of the medical profession and pastoral action, for the only object of both is man, taken in his dignity as a son of God, as a brother needing help and comfort just as we do." John Paul II, *To the World Congress of Catholic Physicians*, October 3, 1982, in *Chiesa e Bioetica. Giovanni Paolo II ai Medici e agli Operatori sanitari*, edited by Dionigi Tettamanzi (Milan: Massimo, 1988), 115.
[18] The concept of "mission" associated with that of the medical profession is a constant theme in the teaching of John Paul II, who recognizes in medicine and its progress "the mission of affirming man's right to life and its dignity." Cf. *Chiesa e Bioetica*, cited above, 333, and also 49, 85, 103, 108, 205.
[19] "People diagnose to cure, provide care to cure, and assist to cure. When this single objective has been inculcated in doctors and nurses, it is not surprising that the dying patient is regarded not only as the symbol of failure, but also as a being who, in not being curable, is outside the professional objective of the doctor and paramedic. Hence the sense of blame, disappointment, and failure which comes to be added to the *syndrome of flight*, reinforcing and aggravating it." Cf. C. Iandolo, *Parlare col malato* (Rome: Armando, 1983), 164
[20] *Ibid.*, 164.
[21] A.M. Burgers and A.M. Burgers, Jr., *Caring for the Patient. A Thrice-Told Tale*, in *New England Journal of Medicine* (1966), 274
[22] "Palliative care" (*cuidados paliativos, soins palliatifs*, palliative medicine, Support Teams) is the term used for a series of actions which by their nature aim to support the terminal patient through attention to the physical, emotional, social, and spiritual aspects of his situation. In Spain there has arisen and is expanding a Palliative Care Society; in Great Britain it is called "The Hospice Movement." Cf. José L. Redrado, O.H., *Derecho a la vida y derecho a la muerte*, in *Labor Hospitalaria*, no. 156 (1975), 64-68, "Cuidados paliativos: La tercera via," in *Ibid.*, no. 220 (1991), 102-113, and H. Taylor, *The Hospice Movement in Britain. Its Role and Its Future* (London: Centre for Policy on Ageing, 1983).
[23] *Jn* 6:54-55.
[24] Cf. *Dolentium Hominum. Church and Health in the World*, no. 1 (1986), 35-36

For a Renewed Alliance Between Medicine and Humanity on the Threshold of the Third Millennium

Address by Cardinal Fiorenzo Angelini at the joint session of the Seventh European Congress of Catholic Medical Associations and the Eighteenth National Congress of the Catholic Medical Association of Italy.

When, in October 1985, the Catholic Physicians of Italy (AMCI), at their Seventeenth National Congress, held in this city, recalled their forty years of existence, the choice of the topic was dictated then as well by the need to view medicine in the perspective of the path of civilization. The subject was, in fact, "Medicine for a Civilization of Peace."

The relationship between medicine and peace is quite close, for we are not peacemakers unless we are servants of life. And if man, every man, in the depth of his heart, aspires to peace and serenity, it is because he loves life. And among the sciences which exalt the progress of civilization, in terms of research and practice, medicine, more than any other, is at the service of life.

Every civilized choice, every historical event, takes on meaning according to whether it places itself on the side of the defense of life or on that of destruction and death. In other words, the road of civilization is marked in its progress or regress by the push it receives from a culture of either life or death.[1]

At this Congress as well, physicians seek to reflect on a subject closely linked to the essential values of civilization: the contribution medicine can make to the progress of humanity on the threshold of the third millennium of the Christian era.

In reviewing the topics to be dealt with in these days, I was struck by an observation which seems contradictory: while on the one hand the extraordinary progress of science and technology as applied to medicine is noted, on the other some subjects are touched upon which weigh upon mankind like a nightmare.

The discoveries of our time are capable of ensuring a quality of life unknown in the past, but at the same time there increasingly hang over us the risks linked to environmental decay and growing pollution. Biotechnology has thinned down the wall separating the different phases of life, prolonging life expectancy and making the most of advanced age; however, the dehumanization of medicine, the abandonment of the spiritual dimension, and the weakening in individual and collective conscience of ethical imperatives have increased to an unforeseeable degree the pathologies connected with a state of solitude and neglect. Solitude and neglect which are exacerbated, among other things, by the split-up of the institution of the family and a model of development which is nourished by the canons of hedonism and consumer society

Hopes for the third millennium are closely subordinated to an increase in cooperation among peoples and the recovery of a Christian dimension to civilization, which is a condition for the full development of a truly human society. At the same time, however, nationalisms surge up again and worrisome tendencies towards racism reappear, and the very need for religious encounter is contrasted by serious manifestations of extremism and fundamentalism.

The unforeseeable events and turmoil which have modified the political, social, and economic order in Europe, the increasingly serious and urgent problems of the immense population of the third world, and the growing, obligatory interdependence of peoples pose a challenge for the Christian conscience which is not simply ideological, but involves witness. Either we will be able, through consistent profession of our faith, to demonstrate the values which can ensure a forward-moving path for civilization, or we will entirely fail in our vocation and mission.

We are, in fact, faced with a historical turning-point demanding not theoretical responses, but life choices, according to the clear indication of John Paul II in *Centesimus Annus*, where we read, "Today more than ever the Church is aware that her social message will be *credible in the witness of works, rather than in its internal consistency and logic*"[2]

I have been asked to introduce the sessions of this Congress with some reflections on the need for a renewed alliance between medicine and humanity on the threshold of the third millennium.

Medicine is a science, and mankind, in order to find in science a factor growth, needs science and technology to move in the direction of civilization. And it is precisely here that we encounter the first serious problem made evident by our time: I am referring to the difficulty of reconciling technical and scientific progress with that of civilization.

Médicos taínos

Scientific Progress and the Road Forward for Civilization

It is then right and proper to ask, On what basis can the encounter between scientific progress and an advance in civilization be fostered? How can we prevent progress from becoming man's enemy rather than being at his service?

There has prevailed in our own culture a conception wherein, when a technological achievement is able to produce a specific result, questions should not be raised about the legitimacy of the processes needed to obtain it

or about the legitimacy of the result itself. In other words, there is an almost generalized conviction that what is technically feasible is also morally acceptable

This false presupposition is at the origin of the gap between scientific and technological progress and the progress of civilization. The former has surpassed the latter, so that civilization risks being left crushed by a technology without an ethical direction and aim.

"Science and technology, precious resources of man when placed at his service and promoting integral development for the benefit of all, cannot by themselves indicate the meaning of existence and human progress. In being ordered to man, from whom they derive their origin and growth, they draw from the person and his moral values an indication of their end and an awareness of their limits." [3]

Only abstractly, then, can we speak of the moral neutrality of scientific research and its applications. Concretely, science and technology need continuous balance as regards the task of serving man; without that reference, they are subject to the very serious risk of being against man.[4] It is not just a fact, but a mentality which is spreading dangerously under the form of a discretionary selection in relation to whole social classes and within them pitting people against each other. The examples superabound.

The legalization of euthanasia is defended by maintaining that it would be "immoral to tolerate, accept, or impose suffering," [5] while current medicine is able to alleviate suffering as never before. The unacceptable motives at its root, to which a hedonistic mentality concerned with the social cost of health care for the incurably ill is related as well, are, on the other hand, silenced

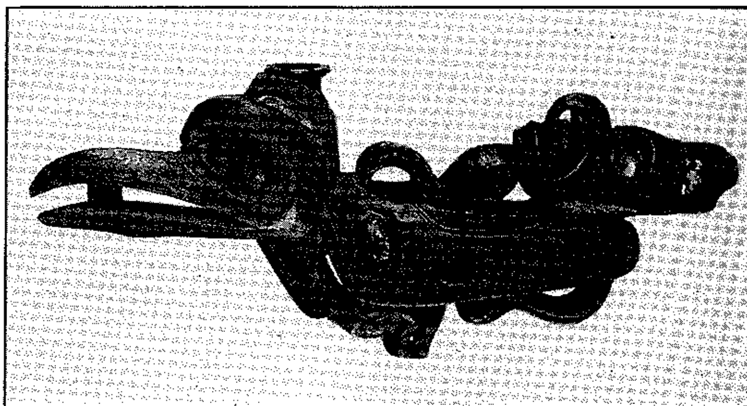
With an insistence worthy of a better cause, there is a desire to maintain a cause/effect relationship between available resources and birth control, forgetting that in many areas of the world characterized by so-called excess population, life expectancy is thirty years lower than that enjoyed by the rich countries. The Church, which maintains the excessively unfamiliar and even less understood doctrine of responsible parenthood, cannot accept, even out of respect for natural law, that responsibility for procreation be replaced by the immoral short cuts of the crime of abortion, sterilization, and contraception.

If technological progress is viewed only as a possibility of generalizing these morally illicit applications, science and technology set themselves against the authentic progress of civilization.

The worrisome gap between technological progress and the progress of civilization is also indicated macroscopically by the so-called ecological question. The inestimable capacity (or, rather, gift) of man of being able to transform his habitat by his own labor, making it increasingly suitable for his growth and maturation, when applied arbitrarily or with improper ends, becomes senseless destruction of the natural environment.[6]

And we are thus witnessing a society or civilization which, while concerned, and rightly so, about safeguarding the natural environment of many animal species threatened with extinction, "is committed too little to safeguarding the moral conditions of an authentic human ecology."[7]

These strident contradictions have now reached such a point of exacerbation that they require a decisive choice of civilization by man. And this choice is necessarily of an ethical nature, for it involves the recovery, or, in any case, the acceptance of a basic ethical principle, awareness of which is already quite widespread at all levels. The principle is this: in order for scientific and technological progress to proceed at the same pace as the progress of human civilization, it is necessary for science and technology to be exclusively at the service of man—that is, of the whole man, in his physical, psychic, and spiritual completeness, and of humanity as a whole. Not service to some at the expense of others or against others, but service to all.



Pipa tlingit

The risks mankind is facing have created the conditions so that, though starting from different ideological, cultural, ethnic, and even religious viewpoints, people arrive at the same conclusion. Since these are risks threatening life and its quality, the service to man to which science and technology are called, enlightened by the impulse of civilization, is a service to life. And we well know that, in the face of the good of life, understood to be the full health of man and psychophysical balance, all barriers fall, and men feel they truly possess the same fundamental, priority right.

In this context, medicine, in its vast range of manifestations —preventive, diagnostic, curative, and rehabilitative, etc.— has an enormous task, for every

solution destined to serve man in what is universally dearest to him calls into play medicine's decisive contribution.

What, then, are the essential, indispensable conditions for an authentic, fruitful alliance between medicine and civilization, or, if we prefer, between medicine and mankind?

Conditions for an Alliance Between Medicine and Civilization

In its richest etymological sense, civilization is essentially *humanitas*. Civilization derives from man and is ordered to man. It would be meaningless to speak of civilization without describing it as *human* civilization.

Indeed, "man is first of all a being who seeks the truth and strives to live it out and examine it deeply in a dialogue involving past and future generations."[8] In this search, man receives a decisive stimulus from the gift of freedom, but "freedom is fully exploited only by acceptance of the truth: in a world without truth freedom loses its consistency, and man is exposed to the violence of the passions and to open or hidden forms of conditioning."[9]

What truth? The one defining the condition of the human being as a creature made in the image and likeness of God. In accepting this truth, we can construct a civilization made to man's measure and for service to man. *Humanitas*, then, is understood as the growth of the individual in himself and as a projection of that growth towards others.

On this basis, while considering that the conditions for an alliance between medicine and humanity are multiple, I would like to limit myself to stressing two of them: the need for a spiritual dimension in science and a humanized medical training.

1 *Spiritual Dimension of Science*

I believe that if there is a truth on which believing and self-styled nonbelieving scientists agree, it is this: man is a mystery. If, then, man is a *mystery*, science, too, is forced to encounter that mystery. The enlightenment and rationalist illusion dreamt of revealing the mystery. Contemporary scientific progress has confirmed that every new discovery must come up against further mysteries.

Man as a mystery must thus be deciphered on a priority basis with regard to the mystery of science, unless we want to give science a direction going off into the dark. The human mystery is in fact constituted by questions on man's destiny, on the meaning of individual and social life—a mystery which cannot be avoided, inasmuch as life ontologically precedes awareness of living.

A science, then, which ignored, did not ask about, or did not help man to understand his mystery would definitely fail in its aim. The believing scientist, on the other hand, even from a methodological standpoint, can be more demanding than someone irrationally assuming the materiality of the human being. In other words, if we agree to view man as mystery in the light of the Christian proposal, there are two possibilities: if we look with faith, our scientific research on man will be illuminated precisely through the certainty coming to us from faith; if we take up the Christian proposal even as a simple working hypothesis, we shall find it to be fruitful and suggestive for research at once serene and inexhaustible.

The *novelty* of Christ, who "worked with the hands of man, thought with the mind of man, acted with the will of man, and loved with the heart of man,"[10] is precisely that of having revealed man to man.[11] Indeed, "through Christ and in Christ that enigma of suffering and death, which apart from the Gospel oppresses us, receives light. With his death he destroyed death; with his resurrection he has made us the gift of life."[12]

For us, who have made faith in Christ the reason for our lives, the spiritual dimension is the ground on which we must move, the frame in which to fit our witness, the inspiration for our work. A spiritual dimension which does not remove us from man, but draws us close to his mystery, which is the mystery of our very life, according to the felicitous affirmation of L. Pasteur: "The greatness of human actions is measured by the inspiration which has prompted them. Happy is he who bears in himself a God, an ideal of beauty, and obeys it: ideal of art, ideal of science, ideal of the fatherland, ideal of the virtue of the Gospel! These are the real living founts of great ideas and great actions."[13]

2. *Humanized Medical Training*

One of the most complete definitions of the humanization of medicine was offered to us by John Paul II in his words at the Second International Conference on "The Humanization of Medicine," organized in 1987 by the Pontifical Council for Pastoral Assistance to Health Care Workers. "Medicine," the Holy Father stated, "inasmuch as it approaches man at the crucial moment of suffering, when he observes an acute need to safeguard his health, must make the one practicing it an expert of great human sensitivity."[14] An expert in both individual relations, "where to humanize means, among other things, openness to all that can predispose us to understand man, his interiority, his world, his psychology, and his culture,"[15] and socially, where "the need for humanization translates into direct involvement by all health workers, each in his own sphere and according to his responsibility, to promote suitable conditions for health, improve inadequate facilities, eliminate the causes of so many illnesses, foster the just distribution of health resources, and make health policy in the world aim only at the welfare of the human person."[16]

No experience of human sensitivity is matured without adequate training, which, for someone professing faith in Christ, must be accompanied by the corresponding spiritual life. It is meaningless to speak of an absence of conflict between science and faith, indeed of necessary interaction and collaboration between thinking and believing, believing and acting, if witness does not shine forth from our activity, our way of organizing relations with others. We do not arrive at this, however, by improvisation, but only through

continued formation which, in addition to drawing upon prayer and consistent conduct in life, must be nourished by the teaching of the Church, which in our time accompanies with growing solicitude both research and practice in medicine.

Since we are able to know what our preparation must be like in this regard, we have the serious duty of ensuring this training for ourselves

The alliance between medicine and humanity can mature only through this rigorous formation, for which we are greatly responsible in relation to the younger and future generations of health professionals

From this Congress there will certainly emerge concrete indications and operative resolutions. It is, however, basic for these to move from clear premises in formulation and method.

Conclusion

Because of this commitment, which particularly calls into play the national Catholic Medical Associations, and that of Italy among them, which by its statute and its history, has always distinguished itself for rigorous, indefectible faithfulness to the Magisterium and the directives of the Church, the perspective of the alliance between medicine and humanity on the threshold of the third millennium in an operative sense takes on a meaning and some special prerogatives which I would like to summarize in this concept: *the Church is counting on you*, along with all health workers professing the Christian faith, *and you can count on the Church*.

In order to count on you the Church needs your courageous witness, which cannot be offered without sacrifice, without intellectual humility, without awareness that freedom of research and expression for science must constantly refer to the objective truth of service to life A service which may require renunciation of personal privileges, refusal of prestigious goals, inasmuch as there cannot be legitimate pride wherever the dignity of the human person may be not only offended, but also not sufficiently respected and exalted

As individuals and as an association you must be convinced of the great truth enunciated by the Second Vatican Council: "the active role of the laity in the life and action of the Church ...is so necessary that without it the very apostolate of the pastors generally cannot reach its full effectiveness " [17]

This involves direct and also creative participation in the action of the Church, of which you are members and a part. In this sphere, your freedom as scientists, researchers, and health professionals will find a vast field for generous dedication, but also for your personal realization, since where it is faith and love which animate our service, freedom is not suffocated or limited, but rather celebrated.

At the same time, however, *you can and must count on the Church*. As President of the Pontifical Council for Pastoral Assistance to Health Care Workers, I invite you to have this firm trust in the support of the institutional Church.

The Office I am honored to preside over, as an organ of stimulation, organization, coordination, and service, is not a bureaucratic structure, but the heart of that healthcare ministry which the Church regards as "an integral part of her mission " [18] What the Pontifical Council has achieved in the few short years of its history is a promising and even gratifying start which has amply confirmed how providential its creation was, in addition to being expectantly awaited.

John Paul II has affirmed that "in the loving and generous welcoming of every human life, especially if weak or ill, the Church is today living out *an fundamental moment* in her mission." [19] "In the Third Millennium as well," the Pope writes in *Centesimus Annus*, "the Church will be faithful in making her own the way of man, aware that she is not proceeding alone, but with Christ her Lord. It is He who has made his own the way of man and guides him, even when man does not realize it." [20]

Aware that the Church is counting on you and that you can count on the Church, do not feel alone, but rather encouraged to overcome all human respect, to make your witness recognizable by taking on the risks of incomprehension as well as the struggle to affirm the truth, which, for medicine, is the truth about man, the image and likeness of God.

May the sessions of this Congress be accompanied by divine aid and the motherly assistance of Our Most Blessed Lady.

[1] John Paul II, Allocution on the Occasion of the Interreligious Encounter in Assisi, October 27, 1986: "Even if there are many important differences among us, is it not perhaps true that, at a deeper level of humanity, there is a common basis on which to work together to solve this dramatic challenge of our era: true peace or catastrophic war?" Cf. *L'Osservatore Romano*, October 28, 1986

[2] Encyclical Letter *Centesimus Annus*, 57

[3] Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life at Its Origin and the Dignity of Procreation* (Rome, 1987), Introduction, 2.

[4] "It would thus be illusory to claim the moral neutrality of scientific research and its applications; moreover, the criteria for orientation cannot be deduced from mere technical efficiency, from the utility they may occasion for some to the detriment of others or, even worse, from the dominant ideologies. Science and technology therefore require, by virtue of their own intrinsic meaning, unconditional respect for the basic criteria of morality—that is, they must be at the service of the human person, of his inalienable rights and his true, integral welfare, according to the project and the will of God " *Ibid.*

[5] Cf the *Manifest on Euthanasia*, which came out in Great Britain in 1974. The *Humanist* (July 1974).

[6] "Man, spurred by the desire to have and enjoy rather than be and grow, consumes the earth's resources and his own life in an excessive, disordered manner At the root of the senseless destruction of the natural environment is an anthropological error, unfortunately widespread in our time Man, who discovers his capacity to transform and, in a certain sense, create the world by his own work, forgets that this is always carried out on the basis of the first, original gift of things by God He

thinks he can arbitrarily dispose of the earth, subjecting it unreservedly to his will, as if it did not have its own form and prior destination given it by God which man can certainly develop, but ought not to betray. Instead of playing his role as God's coworker in the labor of creation, man takes God's place and thus ends up provoking the rebellion of nature, tyrannized rather than governed by him." JOHN PAUL II, Encyclical Letter *Centesimus Annus*, 37.

[7] *Ibid*, 38.

[8] *Ibid*

[9] *Centesimus Annus*, 46

[10] *Gaudium et Spes*, 22.

[11] JOHN PAUL II, Encyclical Letter, *Redemptor Hominis*, 10.

[12] *Ibid*

[13] L. PASTEUR, *Opere*, I, Italian edition (Turin: Utet, 1949), 37

[14] See *Proceedings of the Second International Conference, on "The Humanization of Medicine", Dolentium Hominum Church and Health in the World*, no 3 (1988), note 1, 7

[15] *Ibid*

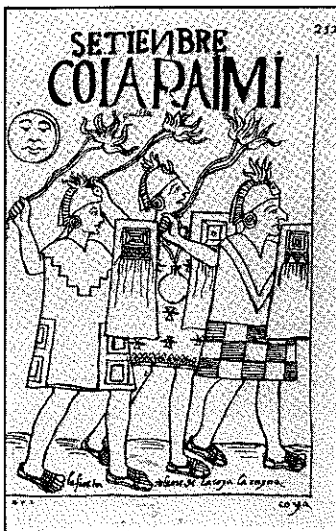
[16] *Ibid*

[17] Decree *Apostolicam Actuositatem*, 10

[18] Cf. Motu Proprio *Dolentium Hominum*, February 11, 1985, no. 1

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

[20] *Centesimus Annus*, 62.



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Man and Medicines

Cardinal Fiorenzo Angelini's words at the Congress on Man and Medicines held in Moscow, April 11, 1992.

In thanking the organizers of this meeting and cordially greeting all present, I would like at the outset to express my satisfaction over having the opportunity today to present some reflections on a subject which is not only of current interest, but has always been linked to the development of medicine as science and practice.

As President of the Pontifical Council for Pastoral Assistance to Health Care Workers, I am pleased to be able to say that this Department, which has arisen to carry out a task of stimulation and promotion within the enormous field of health policy and care, has since its inception dealt especially with everything concerning the complex, delicate, and priority problem of medicines, their availability and use. It was not by chance that the First International Conference organized at the Vatican by the Pontifical Council I have the honor of heading was entitled "Pharmaceuticals at the Service of Human Life."

Like medicine, which, under many aspects, is a development of them, pharmaceuticals are also at the service of human life.

There is a very close relationship between the progress of pharmacology and pharmaceutics and the progress of the quality of life. All the problems connected with the medical sciences encounter an echo and an immediate response in the field of pharmaceutical programming, research, and use. Since its origins medicine has in fact manifested itself above all as the search for medicines, in the sense of antidotes for disease. For this reason, as I have repeated on different occasions, I believe that over the entrances to pharmaceutical research laboratories and at production facilities the following should be written in large letters: "At the Service of Human Life."

The development of preventive, diagnostic, curative, and rehabilitative medicine proceeds at the same pace as the creation of increasingly specific and effective medicines.

The problem of greater social justice directly collides with that of making possible an equitable and reliable distribution of medicines. And the World Health Organization, to guarantee social justice as regards pharmaceuticals on an international scale, has in fact introduced the notion of *essential drugs*. In reality, it is a question of establishing which pharmaceuticals mankind as a whole really needs and then acting so that they will be produced sufficiently and may be distributed according to nondiscretionary criteria in relation to needs

Medicines are not, however, just for providing care and cures, but also, and on an increasingly widespread basis, for preventing illnesses and improving the state of health—that is, of the human person's physical, psychic, and spiritual well-being.

In saying "Man and Medicines," we are not speaking of man in general, but rather of the human person in his sacredness and dignity, in the full expression of his faculties, in the ever more elevated quality of his existence.

These concepts naturally lead to an initial conclusion: the problems posed by pharmaceutical research, programing, and distribution go beyond medical science alone and are situated on the level of an ethical vision of human life. In other words, as John Paul II recalled on October 25, 1986, in his address to participants in the aforementioned International Conference organized by the Department I head, "The development, distribution, and use of pharmaceuticals must be subjected to a particularly rigorous moral code."

Medicines must be capable of responding to the demand for life and dignity emerging from man; they cannot and must not be produced for either nontherapeutic use or to alter the laws of nature to the detriment of the dignity of the human person.

And this dignity must be considered over the whole span of individual life, from conception to its natural close.

The field of application, then, is enormous, and in the face of the major maladies striking man today, two things are urgently required: first, to possess or accept a clear vision of man, of the dignity of his person and of his fundamental rights; secondly, in the domain of these rights, to establish a scale of values and priorities on which, in the case of medicines, it is especially easy to agree.

As for the first point, it is clear that to say "man" is to say all humanity, which, as regards the right to health and to care during illness, has identical rights and cannot be subjected to discrimination. A good many instances of discrimination, before forming part of intentions, are certainly in events—that is, in circumstances with long-standing, complex causes of an anthropological, ethnic, historical, and even climatic nature which only slowly and gradually can be removed. On the other hand, it cannot be acceptable that whereas in some areas of the world it is possible to ensure, by recourse to medicines, proper well-being even in its most subtle nuances, in other areas which are even larger, the *essential* drugs for survival are lacking. The benefits afforted by advances in given sectors must complete and not exclude each other. And we well know that balance in this field is provided not so much by an average which withdraws achievements and resources from one side to ensure them for the other as by a health policy guided by internationally accepted criteria.

The growing interdependence among peoples constitutes an acid test in this regard of extraordinary and priority relevance.

On the second point, the ethical code of behavior requires that service—that is, the promotion and defense of human life, especially beginning with the weakest and most defenseless—be at the summit of the scale of values to be defended through pharmaceutical research, programing, and distribution.

The Catholic Church, which sustains the most noble principle—whose constructive value is recognized today by science as well—of finding value in suffering, has always been at the forefront in helping man to combat suffering, to prevent and treat illness, and to lighten its burden.

Today the Church, especially through the Council for Pastoral Assistance to Health Care Workers, is acquiring in-depth knowledge of the health situation throughout the world with an active presence including over thirty thousand healthcare facilities and offering its cooperation to all national and international organisms, both governmental and nongovernmental, involved in the field of health policy and care.

On the many pastoral trips I have made in recent years all over the world, I have gained first-hand experience of situations of grevious seriousness. Whole populations commonly suffer a lack or scarcity of essential drugs.

Every time an exceptional calamity calls the world's attention to the area affected, we see that the sending of pharmaceuticals is confirmed to be a primary need. Well then, in many developing countries, the pharmaceutical emergency is the norm, indeed the reality of everyday life. And I am referring to essential drugs.

It is thus urgent for international cooperation, continuing along the course embarked upon, to lead to precise knowledge of the problem and study and implement timely solutions inspired by a health policy which always bears in mind the human person's right to life and to its quality.

The substances proposed to contain, check, and kill life at its beginning or accelerate its end when that end is supposedly imminent are *not* medicines, but instruments of death.

Sacrificios y penitencias de los enfermos

Research aimed at sustaining a policy which favors the lives of some while neglecting the lives of others or even at the cost of other lives is not authentic research at the service of life.

Medicines are the gear for man enabling him to traverse the itinerary of his existence. Pharmaceutical science and research are science and research to render this gear more and more suitable and make it available to everyone.

Our subject was "Man and Medicines." It may be read only as follows: "Medicines *for* Man."

The Gospel of Suffering and Early Evangelization in Chile

A Talk by Fiorenzo Cardinal Angelini at the Catholic University of Chile on receiving an Honorary Doctorate in Medicine on September 25, 1992

I am particularly happy that the event celebrating and recalling early evangelization in Latin America has given me the opportunity this year to call attention to an aspect at once essential and glorious of the announcement of the Gospel on this continent, which today groups together the greatest number of Catholics in proportion to its territory

I recently dealt with early evangelization in Latin America and the pastoral care in health which accompanied it in a published work.[1]

The historical revisiting of this evangelization confirms that one of the brightest "lights" lit up by it has been attention to and concern for the suffering and the sick.

The association and even polemical, unjust identification of the conquest and colonization of the New World with its evangelization have led people to underrate an essential aspect of the action carried out by the Church at all levels in the field of assistance to the sick. To deny or omit this truth is an unacceptable lacuna which must be filled It has sufficed for the historians of some religious institutes to consult public archives and their own to find testimony which is itself capable of writing a new—that is, hitherto unknown—chapter on early evangelization in Latin America.

The present occasion gives me a chance only to allude to this subject, with reference to this country. Here, too, early evangelization involved the Church's commitment to the suffering and sick. The concepts of "Gospel of suffering" and "evangelization" thus overlap, almost to the point of identity, for as Christ, through the cross and suffering, carried out redemption, so the Church—though within the sometimes serious limits of the human condition—has always sought to proclaim the Gospel through attention to those who suffer and—following the example of Christ—finding value in suffering itself

If the "new" evangelization hoped for and promoted by John Paul II ought to be such

not, indeed, in its content, but in its zeal, ardor, and manifestation—as the Holy Father loves to repeat—it follows that what was an outstanding aspect of *early* evangelization must also be an aspect of the *new* one On the other hand, the problems concerning health policy and care, though different under many aspects, are no less serious today in either quality or extent than those of about five centuries ago

I feel, however, that it is important in general to stress two elements or aspects which I view as either overlooked or not rightly interpreted in the most widely distributed literature on this five hundredth anniversary.

These are elements and aspects directly regarding health care and medicine which must be underlined, for the Church, in this field and in the period of the discovery, conquest, and colonization of Latin America, performed a decisive function in filling a gap. And this is true for Chile as well, where initial evangelization came later than in other Latin American countries.

Indeed, among the cycles of Spanish American evangelization, historians point to the *Chilean cycle* as markedly dependent upon the Peruvian one, though it was characterized internally by a certain autonomy.[2] This autonomy and singularity have, moreover, accompanied the whole history of this country, which always had a most lofty sense of its dignity, of the right to its freedom, of the nobility of its traditions, and of the strength and pride of its people

The first of the two abovementioned elements or aspects is the following The encounter between European medicine and the New World was neither imposition nor conquest, but a mutual "embrace" In the pharmaceutical and even surgical field, European medicine, after the encounter with that of the New World, embraced innovations which involved the sector of prevention as well.[3] This fact—which awaits further study—not only cancels out a prejudice, but also explains later developments.

The second aspect, broadly documented, is as follows. It is accepted that in the New World the task of health care was almost exclusively carried out by the Church in the period of early evangelization and chiefly by religious (Franciscans, Dominicans, Jesuits, Bethlehemites, Augustinians, Brothers of St. John of God, etc.). These were concerned about introducing into the New World as well the decisive novelties which first John of God and then Camillus De Lellis were gradually introducing into sixteenth-century Europe. There was almost a chronological coincidence between the colonization of the New World—begun, but certainly not concluded in the closing decade of the fifteenth century—and the revolution accomplished by

the two aforementioned saints, whom the Church would later proclaim patrons of hospitals and those working in health care. With John of God a division into wards, the assigning of a bed to every patient, and appropriate dietetics were introduced at medical facilities,[4] while with Camillus De Lellis trafficking in nursing care was gradually replaced by attention based on dedication and profound charity.[5]

The presence and work of religious in the health field marked a step forward of great significance for humanity in medicine.

Furthermore, the "doctrine hospital" (as the medical facility instituted by the Church in the New World was called, in a complex and not easily paraphrased expression) sought to ensure both physical and spiritual care, thereby exalting humanity in its richest meaning —spiritual attention which was no less generous and also no less heroic than strictly medical care, though I do not hesitate to place medicine for the body and medicine for the soul side by side, since Christ, our Master, was a physician of both souls and bodies.

These two aspects contributed effectively to bringing about valuable interaction between European missionaries and evangelizers and local populations, as demonstrated by two clearly ascertained and broadly documented consequences: in the first place, from the time of early evangelization, clinics and hospitals opened and run by the Church admitted native men and women without any discrimination; secondly, local coworkers immediately appeared alongside European doctors and nurses, as proof of the useful encounter between European and New World medicine.

And all of this was particularly exemplified in the course of the later cycles of conquest and colonization, as happened in Peru, Colombia, and Chile.[6]

As I recalled on another occasion,[7] there is an expression by the courageous Dominican who was a leading figure in early evangelization, Bartolomé de Las Casas, which could constitute a key to reading—or, rather, rereading—sixteenth-century New World events. Bartolomé de Las Casas writes that the greatest miracle taking place in the discovery and colonization of Latin America was the fact that the native populations accepted and believed in the God of their oppressors. The assertion by a man who was certainly not indulgent towards the dark side of conquest and colonization leads us to consider oppression itself with a different objectivity.

And not this alone, but what Bartolomé de Las Casas says about the religiosity and religion of the conquered peoples can also be applied to their culture, which accepted many European elements, assimilating them into the patrimony of their own development.

A central mediator of this slow, but constructive process was the Church and particularly the Gospel or, if we prefer, the evangelization of suffering, understood as service to those suffering and announcement of the healing value of suffering itself.

And if the message of "new" evangelization starts from Latin America, the meaning cannot involve a disavowal of the past, but rather a gathering in of its "lights" while overcoming and canceling out its "shadows," which, moreover, have always accompanied evangelization everywhere in the world on account of the disproportion between the greatness of Christ's message and the fragility of his disciples.

Medical care and the health ministry, above all in the modern and contemporary periods, offer a very significant characteristic in relation to evangelization, and particularly witness to Christian justice and charity. They move in the direction of convergence and unity, becoming, in turn, an agent of communion and solidarity among peoples. The examples are numerous and all emblematic.

At the same time as early evangelization of Latin America, assistance to the poor and the sick—warmly recommended by pontifical documents—was inspired by unitary criteria. The Archhospital of the Holy Spirit in Sassia of Rome—which at the time of the Protestant Reform was celebrated for its efficiency and exemplariness by Luther himself—became a force for valuable unification of efforts and collaboration. Founded and supported by an illustrious confraternity, the Roman hospital of the Holy Spirit, the oldest in Europe, twinned itself opportunely with a great many of the hospitals created in the New World—to such a point that today there are over 2,000 affiliates of this hospital around the globe.[8] This form of association favored collaboration and exchange, and not just this, but the organization which the Church was gradually creating in Europe in the field of health care fa-

vored the multiplication of benefactors in support of New World hospitals and spurred the colonizers to entrust to the Church the creation of facilities or rebirth of those undergoing crisis or ruin. There was an example in this very city of Santiago, Chile, whose first hospital was created around 1550 through the efforts of Pedro de Valdivia. In the course of a few decades the hospital fell into such critical condition that the governor invited the St. John of God Brothers in the early 1600's; after coming from Lima, they provided for the renewal of the hospital.[9]

The same occurred in that period in La Concepción, Chile, where there was a royal hospital bearing the name of "Mother of Mercy," at which, in spite of this

title, the sick were so poorly looked after that they died more on this account than because of the diseases afflicting them.[10]

In just a few years the number of beds was tripled, and a fairly numerous community of religious provided for better hospital care.[11]

There was no lack of cases in which the King of Spain by a "royal order" wholly entrusted hospital care for vast territories and entire regions to religious institutes which were at the same time authorized to open new medical facilities.

If I may be allowed to venture a comparison with the contemporary period, I shall state that I regarded it as at once providential and significant that among the first activities of the Pontifical Council for Pastoral Assistance to Health Care Workers, which I have the honor of presiding over, was precisely approaching the Latin American countries, including Cuba, not to mention active participation in the health conferences of the Contadora Group nations and pastoral visits to Latin America. In all of these circumstances one fact has emerged with extraordinary clarity: attention to the problems of Love for life and the need to safeguard and recover health constitute the most universal and common object of faith, and the problems linked to this sector always present themselves as pressing.

The health care and ministry which accompanied early and later evangelization in Chile were frequently of a vanguard type, especially in the struggle against endemic social diseases. The sanatarium-hospital for children suffering from osseo-tuberculosis created by the disciples of St. John of God at Viña del Mar, not far from Valparaiso, for a long time was the only sanatarium of its kind in the whole Republic of Chile.[12] The Church's involvement in care for psychiatric patients and the physically and psychically handicapped—wherein men and women religious have offered even a heroic example of dedication—would deserve separate treatment. Names such as Pedro Manuel Chaparro, José Núñez, Matías del Carmen Verdugo, and Juan Batista Adamés represent as many milestones in the history of health care and the health ministry in this country of yours.[13]

With the approach of the opening of the General Conference of the Latin American Episcopate in Santo Domingo, centering on the new evangelization, I believe that the Church's involvement in medical assistance and pastoral care of the sick—which has abounded since the early evangelization of this continent—gives us some indications which both wisdom and duty oblige us to pursue.

Firstly, it is necessary for pastoral care in health to find a priority place in the new evangelization. As the Holy Father recalls in the Apostolic Exhortation *Christifideles Laici*, in a time like ours, exposed to a rampant "culture of death," assistance to the weak and the sick represents a "fundamental moment in the Church's mission."[14]

The promotion and defense of life and its quality in the weakest and most defenseless constitute promotion and defense of life in absolute terms. It is to choose civilization—a civilization nourished by the message of Christ, who came to give life and give it abundantly.[15]

However, in order for this priority choice to be truly effective and credible, becoming an instrument of authentic evangelization, some conditions must be met, including the following.

1. Not just bishops, priests, and men and women religious, but the *whole Church community must involve itself concretely in service to those suffering.* It is a duty of justice and charity. There is no charity without justice nor true justice without charity. This means that the Gospel of suffering, fully explained by Christ with the parable of the Good Samaritan, teaching us to do good with suffering and do good to him who suffers, is the truest, most tangible, and most effective instrument to affirm the Kingdom of God.[16]

Beginning next year, the whole Church will celebrate the World Day of the Sick. It is significant that, nationally and locally, this initiative has already been implemented in some Latin American countries. It is a new way to announce to the world that the Church recognizes concern for the suffering and infirm to be an integral part of her mission of salvation.[17]

2. Involvement in service to those suffering, though integrally Christian and always performed by the Catholic Church, is not a confessional aspect of her apostolate, but a call rallying all people and institutions animated by good will. *The Gospel of suffering opens itself to the cooperation of all, just as it is addressed to the service of all.* It effects the maximum mediation because it touches man in what is universally dearest to him. In those, too, for whom this service represents a profession, it remains a vocation and a mission, for the whole man—body, psyche, and spirit—is not reached unless man is loved as our brother.

3. *Medical assistance and pastoral care of the sick must support each other and be integrated.* Faith, which recognizes in human life a sharing by grace in the very life of God, points out to science a boundless field for research. Science and medicine, too, if uprightly and generously practiced, are expressions of the "Gospel of suffering" and also contribute decisively to do good with suffering and to do good to those who suffer. The Holy Father has therefore elevated to

the honor of the altars in recent years illustrious scientists and physicians and exemplary health professionals who, through the exercise of their dedication to the suffering, have embodied the example of Christ himself

4. *Lay and especially volunteer-cooperation must be encouraged and supported.* I love to repeat that the places where men suffer and are cared for, hospitals, are the most frequented temple in the world, for virtually all mankind passes through them In this temple the largest, most widely shared, and most convergent liturgical service must be celebrated, which is service to whoever suffers in spirit and in body. In terms of the performance of this service we shall be judged on our faithfulness to the Gospel; [18] indeed, in every suffering person we know we encounter the very Person of Christ, who said He could be recognized in the sick, the afflicted, and the persecuted.

Without the cooperation of the lay faithful, the Pastors' action cannot itself reach its fullness [19] Personally, I shall never be sufficiently grateful to the Lord for having given me the possibility and the grace to experience the value of lay cooperation throughout my ministry as a priest and a Bishop

5. Finally, in the preaching and practice of or witness to the Gospel of suffering, *associations should be favored to the utmost.*

All individualism and every corporative tendency should be avoided. Let generosity in giving and willingness in receiving prevail

In the field of health policy and care, on your continent and in your country as well, the Church possesses great operative strength Let it place itself as a whole at the service of all.

The "shadows" of the past should teach us to correct our limitations; the lights of the past, vastly superior to the shadows,[20] should open the way to new goals.

The institutional Church, through her universal organisms, is not a top-level structure, but the necessary point of anchorage for the action of the entire Church community, which, like Peter and John, by the Beautiful Gate of the Temple of Jerusalem, deprived of everything, still possessed the most precious good—that of restoring health to a sick man [21]

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[1] F. Angelini, *La prima evangelizzazione dell'America Latina e l'attenzione della Chiesa per gli infermi* (Rome, 1992).

[2] E Dussel, *I cicli dell evangelizzazione,* in R Balian, *I missionari della prima ora nell'evangelizzazione dell'America Latina* (Bologna, 1991), p. 37.

[3] Cf. H Obiglio, *Medicine and the Conquistadores,* in *Dolentium Hominum Church and Health in the World,* no 21 (1992)

[4] "It was in fact John of God who dictated new rules to be adopted in the hospital, such as the division into wards, more appropriate dietetics, and the modalities of hospital stay. When in the largest European hospitals as many as five patients shared a single bed, in those of St. John of God each had his own; and that was unheard-of at the time". A. Pazzini, *Assistenza e ospedali nella storia dei Fatebenefratelli* (Torino, 1956), p 11.

[5] Cf. M. Vanti, *I santi dei malati S Giovanni di Dio e S. Camillo de Lellis* (Rome, 1950), p. 38ff.

[6] Cf. O Lazaro, *Para la historia de la Orden Hospitalaria de San Juan de Dios en Hispanoamérica y Filipinas* (Madrid, 1992), p. 237 See also S. Montserrat-Figueras, *Las actividades médico-castrenses de la Inclita Orden Hospitalaria de San Juan de Dios* (Madrid, 1950), pp. 76-78

[7] F. Angelini, *op. cit.*, p. 5

[8] Cf. A. De Angelis, *L'ospedale di Santo Spirito in Sassia e le sue filiali nel mondo* (Rome, 1932).

[9] E M. Laval, *Historia del Hospital San Juan de Dios de Santiago* (Santiago: Biblioteca de la Historia de la Medicina en Chile, 1949).

[10] A Pazzini, *op cit.*, p. 259.

[11] *Ibid.*, p 261.

[12] *Ibid.*, pp. 423-424

[13] *Ibid.*, p. 271.

[14] John Paul II, Apostolic Exhortation *Christifideles Laici,* 38.

[15] *Jn* 10:10.

[16] John Paul II, Apostolic Letter *Salvifici Doloris*, 30

[17] John Paul II, Motu Proprio *Dolentium Hominum*, 1.

[18] Cf *Mt* 25:31-46.

[19] Second Vatican Council, Decree *Apostolicam Actuositatem*, 10

[20] John Paul II, *I cammini del Vangelo*, 5; cf. anche F.J. Arnáis, *Más luces que sombras* (Santo Domingo, 1983).

[21] *Ac* 3:1-10

Catholic Hospitals Around the World

A talk delivered by His Eminence Fiorenzo Cardinal Angelini, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, in Barcelona, Spain, on October 3, 1992 for the 125th Anniversary of the founding of Sant Joan de Déu Hospital.

This day of reflection and study in the context of events commemorating the 125th anniversary of the founding of the Sant Joan de Déu Hospital in Barcelona is focusing on "The Hospital and Human Values."

When I was offered the subject of "Catholic Hospitals Around the World," I was politely asked "to set forth personal life experience rather than statistical data."

I am grateful for this suggestion, for the additional reason that the approximately forty years of close, virtually daily familiarity with the world of suffering and of health policy and care have a statistical value themselves

I have visited and frequented hospitals all over the world—internationally famous hospitals and hospitals endowed with very limited resources; imposing facilities, like your Sant Joan de Déu Hospital, and handmade improvisations Nevertheless, my lived experience in contact with the sick and health professionals has been the same everywhere. Indeed, I do not wish to speak of experience, but rather of the *lesson learned* from all dwelling on the boundless planet of pain or revolving around it.

I say *lesson learned* because I would like it to be clear, first of all, that for a priest, man or woman religious, or bishop what one learns in contact with the sick and health workers, what one receives from them, is much more than one can give, even with maximum dedication

Last year I sought to gather together my experience in the six hundred pages of the volume That Breath on the Clay,[1] but precisely while writing that book I sensed the difficulty of consigning lived experience to the written page.

The concept of *lesson learned* should also be borne in mind when we speak of the identity of the Catholic hospital

I indeed feel that in dealing with this topic it is necessary to clear away two prejudices.

A medical facility's designation or status as *Catholic* should not prompt us to pontificate or feel superior to anyone. The certainties and commitments flowing from adherence to the Gospel of Christ require a spirit of service and availability which ought to be nourished by charity and intellectual humility. In order to serve one stoops, bends towards those suffering in spirit and body

The second prejudice persisting in not a few sectors of the healthcare world is that designation as *Catholic* seeks to imply that for us the hospital has a confessional nature. There could be no greater simplification.

Two years ago, when speaking in Lusaka to the Medical Association of the Churches, I recalled that "the true universal temple, even before our churches and our different religions, is the hospital, the place of refuge and care for all, without distinction, and where people undergo an experience of great spiritual intensity favored by that time of illness, which leads us to reflection and also to the search for and need of the Transcendent, God."[2]

In the face of the question as to what the Catholic hospital is and how it presents itself, we cannot respond in terms of external prerogatives.[3] On the other hand, the very choice of a Catholic hospital by the patient and his relatives must be suggested by an awareness that the values of professionally irreproachable care, love for life and its advancement and defense, and unselfish dedication are ensured by a faith sustained by the grace of God and, therefore, able to offer guarantees not based on human fragility alone or weak laws ambiguous or even unacceptable but on the divine command of love itself.

And I shall close this preamble with a reference which strikes me as particularly timely.

In twenty days the Holy Father John Paul II will proceed to beatify seventy-one Brothers of the Hospital Order of St. John of God martyred during the religious persecution affecting Spain from 1936 to 1939. In those years men and women religious at hospitals ran very serious physical risks Well then, in a circular letter of April 4, 1936, the Superior General of the St. John of God Brothers, though aware of the very serious situation, wrote to the communities in Spain: ". Our religious will not abandon care of the sick until the authorities assume responsibility for them .; let them remain alongside patients until circumstances beyond their control force them to abandon them.... *This will be heroic in some cases*, given the reigning state of anarchy, *but our sacred duty requires it of us.*"[4]

Let the concluding phrase, *sacred* duty, be noted that is, a duty which is certainly human, but is rendered *sacred* by religious consecration, which, as sacred, is able to obtain the strength of heroic dedication from God.

A Catholic hospital, then, is not a hospital *different* from the others, *better* than the others, but in a phrase easier to intuit than to explain what I would call more of a hospital than others, in the sense that the accent is placed only on the guarantee that adherence to Christ, the physician of souls and bodies, is capable of giving to the service offered to those suffering.

To be such, therefore, what characteristics ought the Catholic hospital to possess?

In speaking of a Catholic hospital, I am obviously referring to the term's global application, encompassing therein the health facility, all the personnel employed there, administrative staff, patients, and all visiting the institution

On the basis of my past experience and the visits I continue to make to hospitals throughout the world, I feel I can identify the following characteristics,

which themselves embrace other prerogatives as well carefully examined, moreover, by you in the specialized course held some years ago on this subject [5] and already dealt with in the splendid publication devoted to Sant Joan de Déu Hospital in Barcelona.[6]

First of all, the Catholic hospital must be at the service of life, of all life and of the life of all, from conception to its natural close; secondly, it must be distinguished for professionalness and exemplariness, with respect for the health laws of each country and their full implementation, always within the sphere of the primary value of service to life; thirdly, there must be ensured for all health personnel suitable Christian ethical and moral training; finally, as the most frequented temple in the world, the Catholic hospital must be characterized as a primary place for evangelization.

1. At the Service of Life

Our time suffers from a lack of a "culture of life" and of a prevailing "culture of death." The Holy Father, too, has spoken insistently about this painful aspect, linking the culture of death to the dominant "structures of sin." [7] It strikes me as possible, however, to discern an element of hope in this situation Humanity, while suffering from this "culture of death," is increasingly aware of the most serious phenomenon and, as a result, though experiencing difficulties, it is moving in search of both the values lost and new forms of solidarity. The very historical events which have stunned the world over the last three years have contributed, on the one hand, to exacerbating some aspects of the prevalence of the culture of death, but also to prompting more intense commitment to the construction of a new world order.

The healthcare facility reflects both the dominant culture of death and the growing need to celebrate life. If I were to paraphrase the expression *Catholic hospital*, I would say "a place of service to life, a gift of God." Every other characteristic of Catholicity cannot fail to be linked to this quality.

If Christ characterized his magisterium and ministry as *healing* of the sick in spirit and in body, pointing to this task as the mission of his disciples; [8] if the beginnings of the socialization of medicine are due to the Church; if the Church regards concern for the suffering and sick as an "integral part of her mission," [9] particularly in our time; [10] if "man is the way of the Church,"[11] and is such "[especially] when suffering enters his life," [12] it is because the basic direction of pastoral care is service to life—to all life and to the life of all

2. Professionalness and Exemplariness

Life is not truly served unless it is served in the best way. The adequacy of medical facilities, professionalness of health workers, and exemplariness in hospital management are indispensable characteristics of a Catholic hospital.

An element too often overlooked or not sufficiently valued comes into play here.

Though within limits and even contradictorily, health strategies —that is, everything concerning the health policy, legislation, and programing proper to each country [13]—have made enormous progress in recent decades.

When I speak of the professionalness and exemplariness of the Catholic hospital, I mean that it must become the driving force behind this progress in the perspective of service to life. This involves cooperation and not antagonism, a firm defense of the value of life—carried out, however, through the effective testimony of results In addition, it requires:

— making the most of the capacities of health professionals;
— strict, transparent administration;
— a dedicated commitment to research;
— careful study of the ethical aspects of medical problems;
— openness to the whole healthcare world;
— nondiscrimination regarding the suffering;
— freedom from all instrumentalization which is political or, in any event, foreign to the aims of the healthcare facility;
— respect for the religious creed—whatever it may be—of personal and patients; constant interaction between medical and pastoral care.

I realize that each of these elements would require special examination.

You have asked me to carry out a reflection based on my experience. Well then, where these characteristics are lacking, the Catholic hospital fails in its goal

3. The Ethical and Moral Training of Health Professionals

Experience has often placed me before this disconcerting observation: at Catholic hospitals those responsible for religious assistance are frequently entirely unprepared in the field of health care; in turn, health workers may forget—above all, they ignore—the ethical, moral, and spiritual components of care. The negative consequences of this situation are incalculable, for they artificially separate what the patient lives out in unitary fashion.

The pastoral worker in health does not take the place of the health professional, but both *together* must feel themselves to be at the service of the sick.

And I must say that in Spain this sensibility has been pioneering and has yielded notable fruit. It is not by chance that the Day of the Sick has been celebrated for some time in this country, and the subjects inspiring it each year are along the lines of this interaction between medicine and morality.

When in the late nineteen-sixties, at the Roman headquarters of the National Research Council, I began the annual course on *Medicine* and *Morality*, some thought it was actually an unrealistic step. The course was increasingly successful. It has been replaced, internationally, by the annual Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers.

Let us not forget: either medicine and morality proceed together at the Catholic hospital or the term "Catholic" is devoid of meaning. And I was personally proud of the fact that the

Special Assembly for Europe of the Synod of Bishops unanimously approved the inclusion in the *Concluding Declaration* of an invitation for health professionals to receive moral and bioethical training.[14]

4. The Catholic Hospital as a Primary Place for Evangelization

As I already stated, it is not a question of a "confessional" characterization for the Catholic hospital. Evangelization is not "confessionality" in the reductive, antagonistic sense of the word.

John Paul II has coined the happy expression "Gospel of suffering" to indicate that the liberating, healing announcement of Christ encounters the most fertile soil in those who suffer.

To evangelize so as to offer care, to offer care so as to evangelize.

Whoever, by profession or special consecration, serves his or her suffering brothers and sisters must be able to make this choice visible and credible through that very service to the sick. To serve man, whom Christ has served, means to live again, in our work, Christ's attitude and conduct. If the sick and all those we assist do not recognize in us the features of Christ, we are failing in our very vocation and professional mission.

The decorum of the settings, the efficiency of facilities, the dignity of the service offered, cleanliness, courtesy in external and internal relations, the professionalness of medical and paramedical personnel, seriousness in analyses, timeliness in interventions, respect for the tasks of each—these are all conditions for a testimony of service to man which truly produces the signs of the Christian vocation.

The principal *sign* of service to the suffering as an instrument of evangelization is provided by the intensity and quality of love in our service.

If the choice of serving the suffering arises from an act of love, it cannot fail to reflect the love of God, manifested in Christ and translated into his suffering Face and his bending over the suffering.

Only love can release us from the risk of falling into habit, inurement leading to indifference. The hospital, as a structure and in terms of its efficiency as well, cannot replace the human heart,[15] which in the face of suffering finds in love, above all, the impulse to give its best, never to feel adequate to its responsibilities.

The love asked of us must have those qualities of discretion, sweetness, tenderness, and sharing which we usually regard as maternal. At Catholic facilities, therefore, there should be reference to Our Lady, the loving and sorrowful Mother.

In absolute terms, Catholic hospitals around the world are the greatest force at the service of suffering mankind. The not at all easy census which the Department I am honored to head has been conducting for years has now recorded over 23,000 Catholic healthcare institutions. But this figure still falls short of reality.

These Catholic facilities are geographically distributed in such a way as to be capable of witnessing to the Gospel everywhere in the world.

As the Holy Father reminds us, "In Christ's messianic program... suffering is present in the world to spread love, to cause works of love for our neighbor to arise, to transform all of human civilization into the 'civilization of love'." [16]

The Catholic hospital and Catholic healthcare institutions are the stones to lay the foundations for a—indeed, the only possible—civilization of love.

[1] F. ANGELINI, *Quel soffio sulla creta* (Rome, 1991).

[2] Cf. *Dolentium Hominum. Church and Health in the World*, V, no. 14 (1990), p. 74.

[3] "The question of the Catholic identity of our hospitals is not so much a matter of the crucifix over the bed or the bishops's picture in the lobby or whether or not a nun takes your blood pressure. Catholic identity is a matter of values, not artifacts." Rev. RUSSELL E. SMITH, *Medical Ethics. An Offspring of the Church*, in *Dolentium Hominum. Church and Health in the World*, V, no. 15 (1990), p. 46.

[4] F. LIZASO BERRUETE, O.H., *Braulio M. Corres. Federico Rubio y compañeros mártires hospitalarios de San Juan de Dios* (Madrid, 1992), p. 13.

[5] Cf. *El hospital católico. Material para la reflexión*, in *Labor Hospitalaria*, XV, no. 188 (1983), p. 35.

[6] Cf. *Libro Azul Hospital San Juan de Dios* (Barcelona, 1974).

[7] Cf. JOHN PAUL II, Encyclical Letter *Sollicitudo Rei Socialis*, 43; Apostolic Exhortation *Christifideles Laici*, 38; Encyclical Letter *Centesimus Annus*, 57.

[8] *Lk* 5:17, 6:19, 9:2.

[9] JOHN PAUL II, Motu Proprio *Dolentium Hominum* (1985), no. 1.

[10] "In the loving and generous acceptance of every human life, especially if weak or ill, the Church today is living through a basic moment in her mission, all the more necessary the more dominant a 'culture of death' has become" (*Christifideles Laici*, 38).

[11] JOHN PAUL II, Encyclical Letter *Redemptor Hominis*, 10.14.

[12] JOHN PAUL II, Apostolic Letter *Salvifici Doloris*, 3.

[13] In the phrase "health policy and care," policy embraces each country's health legislation and programing, and *care* includes prevention, diagnosis, treatment, and rehabilitation for the person's optimal psychophysical equilibrium. Cf. F. ANGELINI, *Quel soffio sulla creta* (Rome 1991), p. 3.

[14] "Ius ad valetudinem servandam atque pro posse restituendam omnino tuendum est; sollicitudo totius societatis et pastoralis cura Ecclesiae exerceri debent erga omnes qui morbis laborant, praesertim morbis huius temporis. Omnes valetudinis administri etiam in re morali atque in bioethica formentur." SYNODUS EPISCOPORUM, Coetus Specialis pro Europa, *Declaratio*, 10, in *L'Osservatore Romano*, supplemento, no. 293 (Dec. 20, 1991), VII.

[15] "Le istituzioni sono molto importanti e indispensabili; tuttavia, nessuna istituzione può da sola sostituire il cuore umano, la compassione umana, l'amore umano, l'iniziativa umana, quando si tratti di farsi incontro alla sofferenza dell'altro." JOHN PAUL II, Apostolic Letter *Salvifici Doloris*, 29.

[16] *Ibid.*, 30.

Ceremonia curativa huichol

POLAND

Nursing Homes Dedicated to John Paul II

Cardinal Fiorenzo Angelini traveled to Poland, June 25-30, 1992, with the Secretary of our Office, Fr José L Redrado, to take part in the celebration of the seventieth anniversary of the institution of the Military Academy of Medicine after a brief stopover in Warsaw, where he met with the Apostolic Nuncio, the Most Rev. Jozef Kowalczyk. Cardinal Angelini, accompanied by the Military Ordinary, the Most Rev. Slawoj Leszek Głódź, presided over the Eucharist at the headquarters of the Military Academy in Łódź in the presence of the military and academic authorities and a large throng of people In addition to the homily, he gave a talk to the students at the military academy and veterans. In this connection he met with several bishops —first among them was the Most Rev Władysław Ziółek, Archbishop of Łódź. On June 27, after a stop at the Sanctuary of Jasna Góra in Częstochowa, Cardinal Angelini reached the city of Tarnów, where he was a guest of the Bishop of the Diocese Cardinal Angelini was accompanied throughout by the Superior General of the Benedictine Congregation of Sisters for Reparation to the Holy Face of Our Lord Jesus Christ, Sister M. Maurizia Biancucci, and two other sisters, who at Kupienin, near Tarnów, decided to build a large facility devoted to the elderly sick. It will be named after John Paul II. On June 29, the Solemnity of the Holy Apostles Peter and Paul, after the Eucharistic celebration in the church dedicated to St. Peter and constructed with courageous zeal by Monsignor Zygmunt Zimowski, citizen of Kupienin and Official of the Congregation for the Doctrine of the Faith

The first stone of the building was set in place at the site This cornerstone with which work began had already been blessed personally by the Holy Father. Cardinal Angelini also took part in other, specifically pastoral celebrations, particularly at Medrzechow and in the Cathedral of Tarnów, addressing fifty-nine deacons.

DOMINICAN REPUBLIC

Creation of the Federation of Catholic Physicians in Latin America

The First Congress of Latin American Catholic Medical Associations was held in Santo Domingo, July 9-11, 1992, with the participation of Cardinal Angelini and Fr. Redrado representing the Pontifical Council.

Different institutions actively participated in the Congress, including the International Federation of Catholic Medical Associations (FIAMC), the Latin American Bishops' Conference (CELAM), and representatives of the Catholic Medical Associations of Argentina, Colombia, Jamaica, Paraguay, Peru, Uruguay, Trinidad-Tobago, the Dominican Republic, and members of the Catholic Pontifical University Mater et Magistra of the Dominican Republic

The inaugural ceremony was also attended by the Vice President of the Dominican Republic, Mr Carlos Morales Troncoso, representing the President of the Government, Mr Joaquín Balaguer; Health Secretary Miguel A. Stepan; Cardinal Nicolás López Rodríguez; and the Nuncio of His Holiness, the Most Rev. Fortunato Baldelli.

Two events held during the Congress deserve special mention: the constitution of the Federation of Catholic Physicians of Latin America (FAMCLAM), accompanied by the

naming of the President, two Vice Presidents, the Secretary, and the Treasurer of that Federation, and the conferral upon Cardinal Angelini by the Pontifical University Mater et Magistra of the Dominican Republic of an honorary doctorate in Humanities.

The Congress concentrated on two basic topics: pastoral care in the health field and bioethics training for health professionals Among the talks included, Cardinal Angelini's after receiving the honorary doctorate, entitled "Early Evangelization in Latin America and the Church's Attention to the Suffering," should be recalled In his address the Cardinal stressed that since the moment of the Discovery missionaries had been fulfilling a task of evangelization by instituting a great many hospitals and attending the sick.

Finally, we must also emphasize the Pope's message, conveyed by Cardinal Angelo Sodano, to the Congress participants, in which the Holy Father invited health professionals to give impetus to a new evangelization permeating their mode of action and methods, as in the most glorious periods, and exhorts the new Latin American Federation to respond in a coordinated, convergent, and solidary way to the problems posed today for medicine as science and as praxis The Pope in this message also invites Catholic doctors to be an effective reference point for the defense of the primary values of human life, from its beginning to its natural close, in fidelity to the directives of the Magisterium of the Church.

The Congress served as an important, promising forum for exchanges and solidarity, as witnessed to by the creation of the Latin American Federation, which has aimed since its creation—and we all share this hope—to respond to the expectations which contemporary society poses for the world of health.

CHILE

Pastoral Visit: A Renewed Experience

Cardinal Angelini made a pastoral visit to Chile, accompanied by Fr. José L Redrado, Fr. Lucio Migliacio, Professors Franco Splendori and Gaetano Frayese, and Dr. Dina Nerozzi, Consultors to the Council.

A heavy schedule, largely planned out by Fr. Lucio Migliacio and Fr. Baldo Santi, Vice President of Catholic Charities of Chile, awaited Cardinal Angelini and his entourage First of all was a visit to the Chilean Health Minister, Dr. Jorge Jiménez Dialogue with the Minister focused on the healthcare situation in the country, medical programs, Church-run hospitals, the institution of the World Day of the Sick—its meaning and timeliness to give a Christian direction to the health field, as Cardinal Angelini stressed

At the Catholic University of Valparaíso, Cardinal Angelini delivered a talk on "Lifestyle and Society: AIDS" Afterwards, in Viña del Mar, at the Naval Hospital, there was a meeting with doctors and nurses, before whom Cardinal Angelini spoke on "Humanity for the Dignity of the Sick." The Cardinal and other guests, accompanied by hospital administrators, then visited several wards, greeting patients and their relatives. On the way back to Santiago there was a brief stopover at St. John of God Hospital in Viña del Mar, where some patients were visited in different wards

On the 25th, the Catholic University of Chile conferred upon Cardinal Angelini an honorary doctorate in medicine The university auditorium was festively adorned and a number of academic authorities attended, including the Rector, Professor Juan de Dios Vial Correa, and Professor Flavio Nervi. Among the ecclesiastical authorities were the Grand Chancellor, Archbishop Carlos Oviedo Cavada; Cardinal Francisco Fresno; and Apostolic Nuncio Piero Biggio Among the civil authorities were the Minister of Health and several Ambassadors Before these authorities, students, and other distinguished guests, Cardinal Angelini delivered a lecture entitled "The Gospel of Suffering and Early Evangelization in Chile," which appears in this issue of *Dolentium Hominum*

After the academic ceremony, the cornerstone was blessed of the Center for the Prevention and Treatment of Digestive Cancer and the Chilean Center for Bioethics.

This interesting day concluded at the El Agora Cultural Center, where Cardinal Angelini spoke on AIDS; a good many young people attended.

Our trip came to a close with a visit to the jail, with a special stop at the section reserved for AIDS victims.

Guided by the Center's officers, we had a prolonged conversation with both patients and relatives. It was an emotion-filled, rich experience.

This visit, our Council's second to Chile, served to reinforce our ties in the health field through the university environment by way of rectors, professors, and others. It also facilitated an exchange of criteria and experiences with the local Church, particularly the Apostolic Nuncio, the Most Rev. Piero Biggio, who hosted us and accompanied us during our stay, which was completed by numerous contacts with health professionals and visits to several hospitals.

Our acknowledgement and gratitude go out to the Minister of Health, the local Church as represented by the Apostolic Nuncio, and Fathers Lucio Migliacio and Baldo Santi, of the religious Institute of Regular Clerics of the Mother of God, who put together the program for us and tirelessly accompanied us at every stage.

BARCELONA

The Hospital and Human Values

The St. John of God Children's Hospital in Barcelona is celebrating its 125th anniversary. For this occasion the hospital's religious community and administration have organized different scientific, religious, and cultural events, beginning on October 3, 1992.

This inaugural ceremony was attended by Cardinal Fiorenzo Angelini and Father José L. Redrado. Cardinal Angelini participated in the scientific event entitled "The Hospital and Human Values," where he spoke on "Catholic Hospitals Around the World." During the morning the different topics on the agenda were dealt with: values and interdisciplinary work, information, volunteers, and various kinds of normality. There was a large audience made up of professionals, volunteers, and friends of the hospital, along with health officials of the Catalonian Generalitat, or regional government, and representatives of the local Church, particularly Bishops Carlos Soler and Ramón Daumal.

In the afternoon, Cardinal Angelini met with the Diocesan Delegates for Pastoral Care in Health in Catalonia and then visited the AIDS unit at the St. John of God Residence, greeting these patients personally.

VATICAN CITY

Seventh International Conference: Disabled Persons in Society

The Pontifical Council for Pastoral Assistance to Health Care Workers held its Seventh International Conference, on "Disabled Persons in Society," at the Vatican's Paul VI Auditorium, November 19-21, 1992.

The biblical reference which guided the three intense days was the Pauline statement "Your members are the Body of Christ" (*1 Co* 6:15).

There are over half a million disabled people around the world (40% for genetic reasons and also the victims of life and development models, wars, road accidents, mishaps, pollution, and environmental degradation). This is a social problem of vast dimensions, with implications for the quality of life, medicine and health care, ethics, jurisprudence, and government.

In his remarks, Cardinal Fiorenzo Angelini stressed that all society must make itself "accessible" and affirmed that "a clear vision of life and the dignity of the person will enable architectural, cultural, psychological, and moral barriers to be knocked down." Of the over 30,000 Catholic healthcare institutions around the world, more than half are at the service of the disabled.

The Conference was attended by over 8500 participants proceeding from 99 countries. Among the speakers were seven Nobel Prize winners for Medicine (Axelrod, Dulbecco, Gajdusek, Levi Montalcini, Murray, Weller, and Wiese), the Director General of the World Health Organization, ninety scientists and experts of all disciplines —doctors, researchers, scholars, theologians, and sociologists.

Queen Sylvia of Sweden and Mrs. Mouna Hraoui, the wife of the Lebanese President also spoke.

Many Ministers, including Ministers of Health, forty ambassadors, some heads of governmental organizations, and numerous representatives of Eastern European countries attended.

A group of Cardinals, Archbishops, and Bishops delivered significant talks. A great many disabled people—men and women from many countries and all enthusiastic about the Conference—also made contributions.

On the last day those who had won medals at the Olympic Games for the disabled attended, accompanied by the President of CONI.

The high point of the Conference was the visit and address by the Pope in the same auditorium. The Holy Father affirmed that the disabled also have a right to the dignity corresponding to every human person and that he is counting on the disabled "to explain to the world what love is." The mass media devoted ample attention to the event, by way of interesting newspaper, radio, and TV reports.

Two large screens were set up in the auditorium to project the gestures of interpreters in the language of deaf-mutes.

Medical care was very competently provided by the Sovereign Order of Malta, which made available personnel and equipment to facilitate attendance by the disabled.

The Conference *Proceedings* are to appear in four languages in the journal *Dolentium Hominum* (no. 22, 1/1993), as well as a complete edition in braille.

Rev. LUIGI SECCHI, M.I.

The Pontifical Council for Pastoral Assistance to Health Care Workers

PRESENTA

Giovanni Paolo II e i malati

Il valore della sofferenza

Realizzazione del
CENTRO TELEVISIVO VATICANO

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At present, the Italian language edition of this video is available, and the English version is in preparation. Contact the Pontifical Council for further information.

*JOURNAL OF THE
PONTIFICAL COUNCIL
FOR PASTORAL ASSISTANCE
TO HEALTH CARE WORKERS*

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In the next issue

In the first issue of 1993 we are offering our subscribers the *Proceedings of the Seventh International Conference* organized by the Council, devoted to the Disabled and held at the Vatican in November 1992. Those who are not subscribers to the Journal may obtain the *Proceedings* by writing to our office and enclosing $ 60.