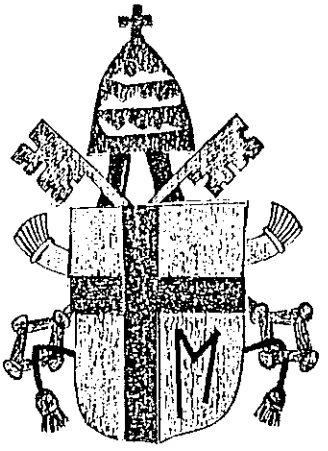

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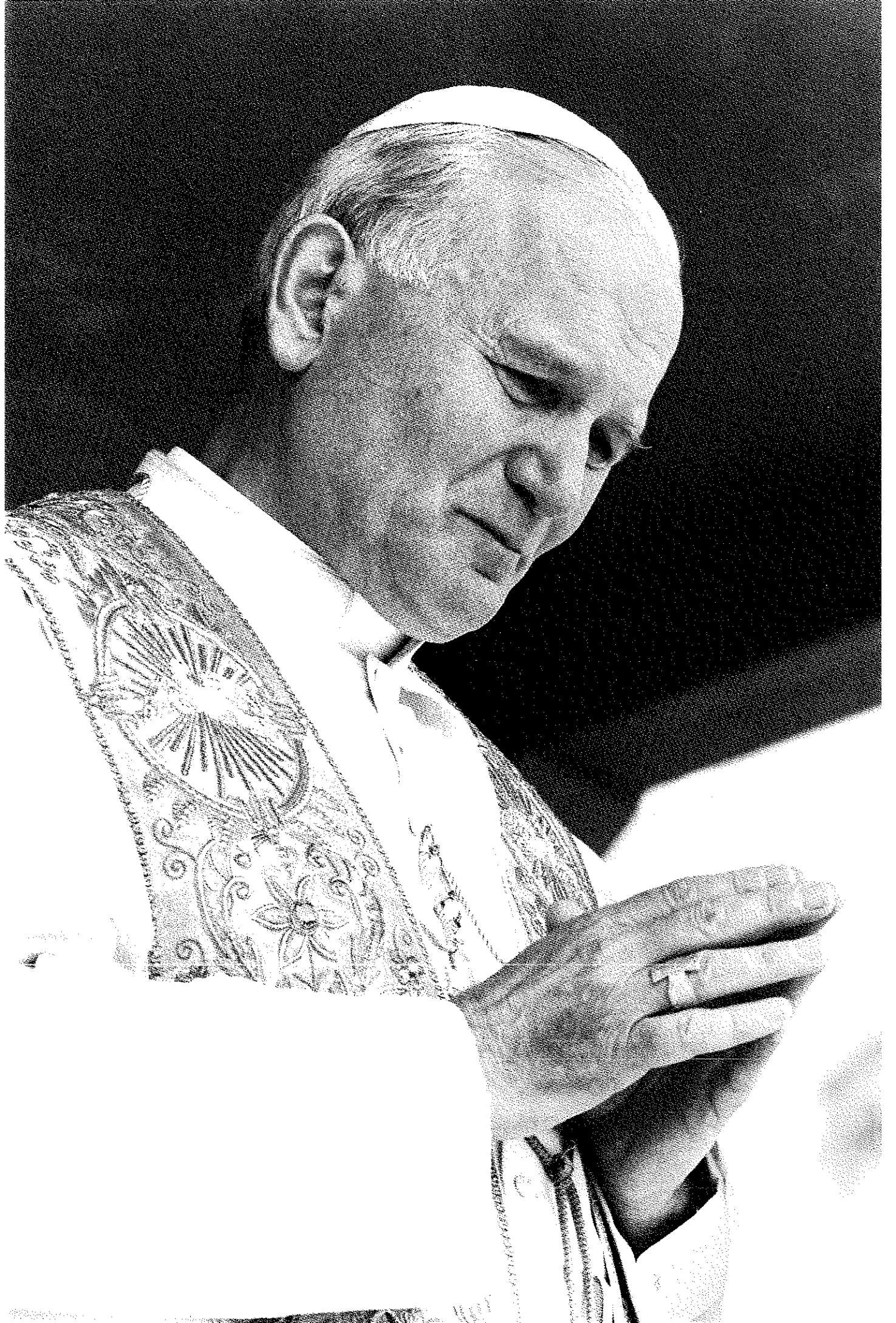
ACTIVITY OF THE PONTIFICAL COUNCIL

The illustrations in this issue have been taken from Giuseppe Finocchiaro D'Inessa's Nel segno della luce *(Troina, Italy. Oasi Maria Santissima)*



MESSAGE OF THE HOLY FATHER for THE SECOND WORLD DAY OF THE SICK 1994

1. I turn my thoughts affectionately to you, brothers and sisters who bear in your body and in your spirit the signs of human suffering, on the significant occasion of the *World Day of the Sick*

I particularly greet you among the sick who have the grace of faith in Christ, Son of the living God, who became man in the womb of the Virgin Mary. In Him, united to all the suffering, crucified and risen again for the salvation of men, you find the strength to undergo your suffering as "salvific pain."

I would like to meet each of you, in every place on earth, to bless you in the name of Jesus Christ, who went about "doing good and healing" the sick (*Ac* 10:38). I would like to be at your side to console you in your afflictions, sustain your courage, nourish your hope, that all of you may be able to make yourselves a gift of love to Christ for the good of the Church and the world.

Like Mary at the foot of the Cross (cf. *Jn* 19:25), I wish to pause at the calvary of so many brothers and sisters who at this moment are lacerated by fratricidal wars, languish in hospitals, or are in mourning for their loved ones who are the victims of violence. The *World Day* will have the Marian sanctuary of Częstochowa as the site of its most solemn celebration this year, to ask for the divine gift of peace through the motherly intercession of the Most Blessed Virgin, along with the spiritual and bodily comfort of the sick or suffering people who silently offer their sacrifices to the Queen of Peace

2. On the occasion of the *World Day of the Sick* I wish to call the attention of you that are ill, of health care workers, of Christians, and of all people of good will to the subject of "salvific pain"—that is, the Christian meaning of suffering, a topic upon which I dwelt in the Apostolic Letter *Salvifici Doloris*, published on February 11th, ten years ago.

How can we speak of salvific pain? Is suffering not an obstacle to happiness and a motive for separation from God? There are undoubtedly tribulations which, from a human point of view, seem devoid of any meaning.

In reality, if the Lord Jesus, Incarnate Word, has declared, "Blessed are the afflicted" (*Mt* 5:4), it is because a higher point of view exists, that of God, who calls everyone to life and, though by way of pain and death, to his eternal Kingdom of love and peace.

Happy is the person who succeeds in making God's light shine in the poverty of a suffering or diminished life!

3. To obtain this light on pain, we must first of all listen to the Word of God, found in the books of Sacred Scripture, which can also be termed "a great book on suffering" (*Salvifici Doloris*, 6). Therein we in fact encounter not only "an extensive listing of situations which in varied ways are painful for man" (*ibid.*, 7), but also the experience of multiform evil which inevitably prompts the question "Why?" (*ibid.*, 9).

In the Book of Job this question is most dramatically expressed and at the same time given an initial, partial answer. The story of that just man, tried in every way in spite of his innocence, shows that "it is not true that all suffering is a consequence of sin and has the character of punishment" (*ibid.*, 11).

The full and definitive answer to Job is Christ. "Only in the mystery of the Incarnate Word does the mystery of man find true light" (*Gaudium et Spes*, 22). In Christ even pain is taken up into the mystery of *infinite charity*, which radiates out from God the Trinity and becomes an expression of love and instrument of redemption—that is, it becomes salvific pain.

It is in fact the Father who chooses the total gift of the Son as the way to restore the alliance with men rendered ineffective by sin: "God so loved the world that He gave his only-begotten Son so that anyone who believes in Him will not die, but have eternal life" (*Jn* 3:16).

It is the *Son* who "heads towards his suffering; aware of its saving power, He goes obediently to the Father, but first of all *He is united to the Father in this love*, with which He has loved the world and man in the world" (*Salvifici Doloris*, 16).

It is the *Holy Spirit*, speaking through the Prophets, who announced the sufferings which the Messiah voluntarily embraced for men and to some extent in place of men: "He has burdened Himself with our sufferings; He has taken upon Himself our pains.... The Lord made the iniquity of all of us fall upon Him" (*Is* 53:4-6).

4. Brothers and Sisters, let us admire the loving plan of divine Wisdom! Christ "has drawn near... to the world of suffering by the very fact that He has taken this suffering upon Himself" (*Salvifici Doloris*, 16): He became like us in everything, except sin (cf. *Heb* 4:15; *1 P* 2:22); He took on the human condition with all its limits, including death (cf. *Ph* 2:7-8); He offered his life for us (cf. *Jn* 10:17; *1 Jn* 3:16), so that we might live by the new life in the Spirit (cf. *Rm* 6:4, 8:9-11).

It sometimes happens that under the weight of acute, unbearable pain someone directs a reproach at God, accusing Him of injustice; but the lament dies on the lips of whoever contemplates the Crucified One suffering "voluntarily" and "innocently" (*Salvifici Doloris*, 18). We cannot reproach a God uniting Himself to human sufferings!

5. A perfect revelation of the salvific value of pain is the passion of the Lord: "In the cross of Christ not only has redemption been fulfilled through suffering, but suffering itself has also been redeemed" (*ibid.*, 19). Christ "opened his suffering to man," and in Him man rediscovers his sufferings "enriched with a new content and a new meaning" (*ibid.*, 20).

Reason, which already grasps the distinction existing between pain and evil, when illuminated by faith comprehends that all suffering can, through

grace, become a prolongation of the mystery of the Redemption, which, though complete in Christ, "constantly remains open to all love which is expressed in human suffering" (*ibid*., 24)

All of the tribulations of life can become signs and foundations of future glory. "In the measure in which you share in the sufferings of Christ," the First Letter of Peter exhorts, "rejoice so that you may also rejoice and exult in the revelation of his glory" (*1 P* 4:13).

6. Dear people who are ill, you know from experience that in your situation you need examples more than words. Yes, we all need models spurring us to walk the road of the sanctification of pain.

On this commemoration of Our Lady of Lourdes, let us gaze at Mary as a *living icon of the Gospel of suffering*.

Call to mind the episodes in her life. You will find Mary in the poverty of the house in Nazareth, in the humiliation of the stable in Bethlehem, in the privations of the flight into the land of Egypt, in the exertion of humble, blessed work with Jesus and Joseph.

Especially after the prophecy of Simeon, who predicted the Mother's sharing in the suffering of the Son (*Lk* 2:34), Mary on a deep level experienced a mysterious presage of pain. Together with her Son, she, too, began to head towards the Cross. "It was on Calvary that the suffering of the Blessed Virgin Mary, alongside that of Christ, reached a peak which is indeed difficult to imagine in its loftiness from a human standpoint, but which is certainly mysterious and supernaturally fruitful for the purposes of universal salvation" (*Salvifici Doloris*, 25).

The Mother of Jesus was preserved from sin, but not from suffering. The Christian people thus identifies with the figure of Our Lady of Sorrows, discerning its own pain in hers. In contemplating her, each of the faithful is introduced more intimately into the mystery of Christ and his salvific pain.

Let us seek to enter into communion with the Immaculate Heart of the Mother of Jesus, where the pain of the Son for the world's salvation was reflected in a unique and incomparable way. Let us receive Mary, designated the spiritual mother of his disciples by the dying Christ, and entrust ourselves to Her so as to be faithful to God on the journey from Baptism to glory.

7. I now address you, health care workers, doctors, men and women nurses, chaplains and women religious, technical and administrative personnel, social workers, and volunteers.

Like the Good Samaritan, you are close to and serve the sick and suffering, respecting—first of all, and always—their dignity as persons, and, with the eyes of faith, recognizing the presence of the suffering Jesus in them. Guard against the indifference which can result from habit; every day renew your commitment to being brothers or sisters to all, with no discrimination; to the irreplaceable contribution of your professionalism, joined to the adequacy of facilities, add the "heart," which alone can give them humanity (*Salvifici Doloris*, 29).

8. Finally, I appeal to you that are leaders of nations, that you may consider health to be a priority problem on a world level.

One of the aims of the *World Day of the Sick* is to carry out a vast effort to increase awareness of the serious and inescapable problems con-

cerning health policy and care. About two-thirds of mankind still lack essential medical care, while the resources employed in this sector are too often insufficient. May the World Health Organization's program —"Health for All by the Year 2000"—which might appear to be a mirage, instead prompt constructive rivalry in effective solidarity. The extraordinary progress of science and technology and the development of the mass media contribute to making this hope ever firmer.

9. Dear people who are ill: sustained by faith, face evil in all its forms without becoming discouraged and yielding to pessimism. Take the opportunity opened up by Christ to transform your situation into an expression of grace and love. Then your pain, too, will become salvific and contribute to completing the suffering of Christ for the benefit of his Body, which is the Church (cf. *Col* 1:24).

I wish all of you and health care workers and everyone devoted to serving the suffering grace and peace, salvation and health, vital strength, assiduous commitment, and unfailing hope. Along with the motherly assistance of Our Lady, *Salus Infirmorum*, may you always be accompanied and comforted by my affectionate Blessing.

From the Vatican, December 8, 1993.

The Encyclical *Veritatis Splendor*: A New Milestone in the Clarification of Catholic Moral Doctrine

1. The Point of Departure and the Motive

I have just slowly and carefully read and reread this monumental Encyclical by Pope John Paul II, and although I am sure that I will discover new and more important nuances in more meticulous study, this first reading suggests to me a good many reflections.

Perhaps the transcendence of this new, splendid document of the Magisterium will not be immediately grasped and valued in its full scope by the great multitude of Catholics as it can be by experts. This is only to be expected, for this statement of the backbone of Catholic morality presupposes broad prior knowledge and information on the situation created for contemporary moral theology by certain conceptions (now clearly identified and defined by the Encyclical) which have been spreading progressively to the point of being presented as the "true Christian reading" of moral theology. For this very reason it will be necessary to carry on an extensive, patient effort at instruction in the future.

But those of us who have been engaged in research and teaching of moral theology for many years are well aware of such conceptions (dealt with in detail by the Encyclical's second chapter), and they have been a source of deep concern, for they imply a radical modification of moral criteria on quite a few serious problems. These conceptions provided the circumstantial motivation for this new and indispensable reformulation of the foundations of Catholic morality, since "it is no longer a matter of partial and occasional objections, but, rather, on the basis of certain anthropological and ethical conceptions, the moral heritage is questioned globally and systematically" (*Introduction*, no. 4). It is true that in the past the Magisterium had pronounced on innumerable moral subjects; it is true that it had also warned in passing, in other important, more recent documents, about the catastrophic influence of those errors, which had daily become more widespread. But a broader and clearer statement by the Magisterium on such vital questions had now been felt to be urgent. Hence the Encyclical *Veritatis Splendor* does not limit itself to identifying them and refuting their arguments: it seeks, above all, to show the true origin and authentic source of inspiration for the moral judgment of the faithful Catholic. And both are summarized in Christ's answer to the moral question. In this way the Encyclical recalls that, for the Church, the life of faith and moral life (in themselves inseparable) emanate from one and the same divine revelation: only in the light of the Gospel teachings can we know what is morally good or bad.

The ideal of Christian perfection (= holiness) is rooted in the fulfillment of the commandments, the living out of the proposals in the Sermon on the Mount, the exercise of charity, etc. Either morality is the road to true happiness, or it is nothing. We thus find ourselves before an exposition of "the Church's moral teaching as a whole, with the precise aim of recalling certain basic truths of Catholic doctrine which in the current context run the risk of being deformed or denied" (*ibid.*).

2. A Key Question

A key question spontaneously arises in the mind of the reader of the Encyclical's second chapter: Why have those principles been maintained, and what are they attempting to resolve? I myself have been asking this same question for years; as the writings of those maintaining them are progressively examined with objectivity, the answer becomes increasingly clear. The postmodern period, with its spectacular advances in the field of science and technology, with its profound cultural, economic, and social transformations, has posed new and momentous questions, particularly of a moral nature. Let it suffice just to recall, for instance, the numerous debates prompted by the abundant and novel topics in the discipline which has come to be called "bioethics." To many Catholic thinkers it seemed that traditional moral parameters, regarded as excessively rigid and abstract, impeded a "more humane solution" to that vast range of problems in which a large part of mankind is immersed. They eventually became convinced of the need for

"mitigating" moral criteria, thinking they could make the Christian proposal "more tolerable" in that way. Observing that, in the light of the classical guidelines always taught by the Magisterium and theology, there was, in their view, no satisfactory formal solution to such problems, they felt the time had arrived to revise the principles themselves. In short, it was a matter of finding a point for "transaction." Here lies the explanation for the epigraph of this second chapter: "Do not conform yourselves to the mentality of this world" (*Rm* 12:2).

At the start of this "revisionist" process certain modern conceptions of freedom already exerted notable influence: either an exaggerated idea of individual autonomy or, in an opposite and paradoxical sense, a radical negation of freedom (nos. 32-33). I remember how, at the end of the nineteen-forties and during the nineteen-fifties (that is, just after the second world war), the thesis of a dialectical opposition between law and freedom, law and grace, justice and charity, institution and charism, Magisterium and prophecy, and authoritarianism and freedom in theological research and expression, to cite some examples, insinuated itself into the domain of theology, in an attempt at applying such criteria to supposedly correct inter-church relations. It was at that point when an underground current appeared which had begun to germinate long before; starting from merciless criticism of prior scholastic morality, it eventually questioned the very authority and competence of the Ordinary Magisterium of the Church in moral matters.

Pope Pius XII then warned about the consequences of "situation ethics"; that current began to contaminate the ranks of Catholics and inexorably led to radical moral relativism. The process reached the point of crisis at the time of the Second Vatican Council (though it has been assumed to have done so, the Council did not echo that process) and culminated in the subject of contraception, virulently exploding as a result of the publication of the Encyclical *Humanae Vitae*. Never had objections to the authority of the Magisterium (with the exception of Luther in the sixteenth century) reached such a degree of daring, including statements by several Bishops' Conferences drafted with the excuse of seeking convergence and making the norm intelligible. I set aside the extravagant incidents piloted by groups of theologians in different areas seeking to put their own authority on a par with the Pontifical Magisterium; they forgot that when precepts and rulings on doctrinal questions promulgated by the Supreme Pontiff are involved, even of a moral order, the faithful cannot resort to the saying used for the judgments of individual theologians: "One's authority is as valid as are one's reasons." Even if what is ordered and taught by the Church in her Ordinary Magisterium does not convince anyone on the basis of the reasons presented, people are nevertheless obliged to obey it all the same, for that teaching obliges them "not only because of the reasons adduced, but, above all, on account of the light of the Holy Spirit, with which the Pastors of the Church are specially assisted so as to clarify the truth." [1] But what is certain is that, beginning with those events, the theories now reprobated by *Veritatis Splendor* began to enter into the public domain. The first assault was against the classical concept of "natural law," which, according to these theologians, had been interpreted in a merely physicalistic or biologistic sense by previous theology and by the Magisterium of the Church. A change

ought to be effected on the basis of a new concept of nature revealed by scientific advances; a mutually exclusive dialectical opposition was thus established between nature and person.

Natural law's properties of universality and immutability were shelved, and the absence of absolute norms in moral theology was maintained. The morality of the conscience (the old delirium of former times) sought to replace the morality of virtues; conscience changed from the judgment of practical reason in applying objective moral norms to the specific case into judgment creating personal norms.

The existence of intrinsically evil acts (evil because of their objects) was denied, as it was only the subject's intention which determined the goodness or evil of an action. The morality of the "fundamental option" imposed itself upon the morality of concrete acts; the moral dimension was not to be measured by the matter of single acts, but by "calculation of the 'consequences' which are foreseen as deriving from the execution of a decision," or by the consideration of the values and goods pursued, with a focus on "the proportion recognized between the good or bad effects in view of the 'greater good' or 'lesser evil' which are effectively possible in a given situation" (Chapter II, no 75) The Encyclical explains why these theses are incompatible with the Catholic morality invariably proposed by the Magisterium over the course of the centuries The notions of mortal and venial sin are profoundly altered in all of these interpretations: they clearly put into question the recurrent frequency of mortal sin, which they circumscribe as a rare, hypothetical case in moral life.

With these hypotheses there was an attempt to legitimize morally contraceptive acts in marital relations and premarital relations under certain circumstances, the masturbation of adolescents (on the basis of supposedly new psychological criteria) or adults (aimed at solving problems of sterility), certain types of abortion, recourse to artificial procreation, some cases of euthanasia, condom use to prevent AIDS and other diseases, or even isolated acts of marital infidelity, according to the less scrupulous. Clearly, once the moral principle is proposed, it can be applied up to the final consequences And those hypotheses, conceived to mitigate the evil of certain acts in the area of sexuality, could be readily applied to many other moral subjects, with a foreseeable upheaval in the entire structure of morality and an inevitable relaxation of customs.

All of these postures may provoke the sympathy of postmodern society, from which every objective moral context seems to have disappeared, but they do not agree with the ideal of Christian life, which, as the final chapter of *Veritatis Splendor* recalls, may require heroic attitudes in the face of certain situations "so as not to deform the Cross of Christ" (*1 Co* 1:17).

The Encyclical does not cite the names of works and authors, but it is not hard to identify them since all of these ideas have been written and defended publicly.

3. The Impact of the Encyclical

What has been and will be the reaction to *Veritatis Splendor*? The international press seems to have received it with indifference, limiting itself to reporting on its publication and reproducing scanty (and woefully imprecise) summaries of its content. One gets the impression that the document has disappointed them somewhat: they expected a setting forth of specific topics which are always the object of sensationalistic controversies and comments But the irritated voices of some moralists who have defended those theories and will not let their arms be twisted will certainly be raised against it. Yet, however much they resent it, *alea jacta est*: the lots are cast for their theories. We could exclaim with St. Augustine, "Rome has spoken; the case is closed." Undoubtedly, as has occurred on other occasions (and in recent times with a frequency which was not usual in the past), many will continue to persist in their postures and attempt to go on defending them Nevertheless, this clear and solid reformulation by the Magisterium of the foundations of Catholic morality will have a clarifying effect for most of the Catholic faithful, who continue to believe in the wisdom of the Church and the power of Him who inspires her. In the long run, the truth will eventually impose itself It is to be hoped that the *Catechism of the Catholic Church* and *Veritatis Splendor* will exert a marked influence on the new generations.

Those of us carrying out the task of research and teaching in moral theology will find it quite fruitful to reflect serenely on the warnings and exhortations which the Supreme Pontiff addresses to us concerning our specific service to the Church (nos. 109-113). For all of us the time has come for humility and obedience

Fr. DOMINGO BASSO, O.P.

[1] Paul VI, Encyclical *Humanae Vitae*, no. 28; cf. Pius XII, Address *Magnificate Dominum*, Nov. 7, 1954

Pastoral Care in Health at the Forty-Fifth International Eucharistic Congress in Seville

The Forty-Fifth International Eucharistic Congress took place in Seville, June 7-13, 1993, convened by His Holiness John Paul II, on the subject "Christ, the Light of the Peoples," and with the basic aim of spurring a new evangelization. The sick and all health care workers were called to take part in this universal assembly. This chronicle simply seeks to express with fidelity and fervent recollection our witness to this participation.

Preparation for the Congress

From the outset Monsignor Oliver Román, General Secretary of the Eucharistic Congress, insisted on the need for active, lively, and illuminating participation by the sick. Spanish Pastoral Care in Health took up that invitation and with the characteristic enthusiasm and generosity of Rudesindo Delgado, the National Delegate, proposed to direct the world of health towards the objectives, contents, and activities of the Congress, seeking, through the evangelizing presence of the sick, to deepen and enrich the celebration of the Eucharist and the action of the whole Church

In December 1992 we celebrated a Regional Meeting to prepare the Congress presided over by Rudesindo Delgado and Pedro Núñez, Superior of the Sacramentines in Spain.

Patients and pastoral workers, diocesan delegates, religious, chaplains, and health professionals (PROSAC organization) reflected on the Eucharist and the sick and drew up their objectives.

— To make patients' participation in the Eucharist conscious and full so that it will thus announce their dignity and rights and denounce the injustices of society in the world of health.

To affirm that we patients have experienced Jesus in the Eucharist as the companion walking at our side and giving us strength to evangelize with gestures and words.

— To communicate that in the Eucharist, the way to light and life, the patient manages to experience the evangelizing energy of illness, overcoming the challenge of suffering through mercy, joy, and hope.

In order to reach these objectives, the following was proposed

— Drawing up a message from the sick to society. To this end questionnaires were distributed throughout Spain in which the sick were invited to send to the Congress testimony of their experience of illness and the Eucharist as a source of health and life. More than three hundred testimonies were gathered together and with them a text was drawn up to be read at a ceremony during the Congress and a book to be presented to the Holy Father in the Statio Orbis.

— A campaign aimed at eliminating architectural barriers and facilitating real participation by patients in Eucharistic celebrations

— To promote the donation of organs and blood by health professionals and pastors of the Church

— In this regard, the Christian health professionals of the diocese of Seville published a manifest in which they stimulated awareness of this need and invited everyone to take part in an organ-donation campaign, and, as a gesture of Christian solidarity, more than thirty PROSAC members (lay health workers) signed a notarized document manifesting their desire to become organ donors. All of PROSAC in Spain adhered to this campaign at the Seventh National Meeting, which took place in Galicia in April

Congress Events

On Friday, June 11, the celebration of the Anointing of the Sick took place at the Hospital of St. John of God at a Eucharist at which Cardinal Angelini, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, presided The ceremony was at once solemn and spontaneous, moving, and unforgettable for those of us who had the good fortune to be there: patients at the hospital and from several par-

ishes in the diocese of Seville, a group of Koreans, another of Polish children, some Colombians, family members, pastors, chaplains, men and women religious, and a good many PROSAC members As an official ceremony of the Congress it was marked by the presence of the Pontifical Legate, Cardinal Nicolás López Rodríguez, and the Most Rev. Carlos Amigo Vallejo, Archbishop of Seville.

The setting, which had been prepared with the beautiful simplicity of the Brothers of St John of God, proved splendid. The radiant light of the Seville spring rendered more visible the presence of God, which was perceived in the modesty of the little details, the flowers in the patio, the warbling of the birds, the silence, the emotion of the elderly, or the smile of a child.

The participation of the sick was intense and heartfelt—a blind youth proclaimed the first reading; a paraplegic woman, the second. Cardinal Angelini delivered a beautiful and emotional homily and made numerous gestures of affection for the sick. In the offerings, the sick presented the Book of Testimonies; the PROSAC members, the affidavit regarding the donation of their organs; and two religious, the book containing a compilation of all the Church's health facilities around the world. After Communion, a woman patient read the "Message of the Sick on the Occasion of the Eucharist Congress." This text made a strong impact on those present.

At the closing Eucharist, the Statio Orbis, at which the Holy Father presided, the world of health was present, represented by more than 2500 people, including the sick, their families, health care workers, religious, and professionals. The Spanish request in the Prayer of the Faithful was made by a blind child. Among the offerings one patient, assisted by his wife, presented the *Book of Testimonies* And, before beginning to distribute Communion to the faithful, His Holiness John Paul II entrusted to two Extraordinary Ministers the Sacred Forms intended for the sick people following the celebration in their homes or hospitals, and two of them received Communion directly from the Pope.

Those of us with the good fortune to be there will find it hard to forget such moments. Through them the world perceived in the sick the real face of God, and we were witnesses to his Light

Dioocesan Department
for Pastoral Care in Health, Seville, Spain

Message from the Sick

This message was drawn up with the contributions of numerous sick people from all over Spain. It was read at the Eucharist and Anointing of the Sick celebrated on June 11, 1993 at the Hospital of St. John of God in Seville. Cardinal Angelini, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, presided at the celebration.

We who are ill joyfully accept the invitation to take part in the International Eucharistic Congress in Seville. In the Eucharist which we are celebrating we have been anointed with the *oil of the sick*. Responding to the mission Jesus entrusts to us to evangelize through illness, we offer this message of hope.

There are many who, like us, live through the experience of illness It is very hard and painful to be sick, feel limited and weak, not to manage on your own, depend on others, suffer, and see your loved ones suffering ... With illness the world collapses upon you.

We all have moments of discouragement, impatience, and even despair. Nevertheless, thanks to the affection and support of our families, the attention of health personnel, the prayers of our community, the company of friends, and faith in God, many of us have overcome the hard times and, having recovered the will to live and hope, we bear our illness with serenity and even joy.

In the *celebrated Eucharist*, we feel Jesus loves us, is with us, enlightens our existence, heals our wounds, gives us strength to do the will of God, and invites us to be his witnesses. In the *worshipped Eucharist*, Jesus com-

forts us, supports us, and helps us to find meaning in our suffering, live through it with love, and offer it for the Church and mankind. In the *lived Eucharist*, we experience the joy of being united with those who suffer, of sharing the peace and joy which God gives us, and of helping others to be more generous and live with hope.

To the Sick

Live each moment of your lives. Do not let yourselves get dragged down by discouragement, but struggle valiantly. Be patient. If you cannot overcome illness, live with it, and do not grow bitter. Look at the good part of life and develop all the potentialities that are in you. Do not lack faith, trust in God, and place yourselves in his hands. Unite yourselves to Christ in the Eucharist, which is the "remembrance" of suffering on the Cross and the joy of the Resurrection. Join with your Christian community and take part in its life and activities.

To the Families of the Sick

We thank you for everything you do for us. Your affection and understanding make our illness more bearable and give us strength to live. Be patient with us and forgive us for the inconvenience we cause you. It pains us to make you suffer. Trust in God. He will be your help. May illness not break the family, but keep it united.

To Health Personnel

We wish to convey to you our appreciation and gratitude for the service you provide to the sick and for the competence and generosity with which you do so. You are the kind face in the midst of pain. Continue in your noble purpose of making health care humane. May the Lord fill you with his gifts!

To the Christian Communities

Those of us who are ill need the warmth, support, and company of our parish community. Thank you for visiting us. Thank you for offering us the Word of God and bringing us Communion. Thank you for your prayers. Thank you for being close to our families.

Count on the sick. We, too, are the Church and have a mission in her. Treat us not as useless beings, but as brothers and sisters who wish to take part *actively* in the life of the community. Eliminate the barriers preventing us from doing so or making it difficult.

To Those Who Feel Far from God

Through our experience we assure you that God loves you. Approach Him with confidence, and you will discover Him. Be united to those who suffer, visit hospitals, deal with the sick, and you will see the hand of God. We request the gift of faith for you.

To conclude, we want to thank John Paul II for the example of integrity with which he has borne his illness, for the affection with which he treats the sick, for his constant words of encouragement, and for having instituted the World Day of the Sick. We ask the Lord that he may not grow tired, that we may not tire, of augmenting solidarity with the neediest and working for peace. We implore his blessing upon ourselves and our families, on the world's sick, and on those promoting health, preventing illnesses, and caring for the sick.

Seville, June 11, 1993

Celebration of the Anointing of the Sick

Homily by Cardinal Fiorenzo Angelini during Holy Mass at the Forty-Fifth International Eucharistic Congress in Seville, June 11, 1993

This day, and particularly this celebration, is a moment of intense and profound emotion for me, as it is for you. And I am happy, as President of the Pontifical Council for Pastoral Assistance to Health Care Workers, accompanied by the Secretary of our Office, Fr. José Luis Redrado, to be taking part today in this gathering with you for prayer.

I also feel it is especially significant that this Eucharistic celebration should recall, include, and express such numerous and vital motives for reflection, prayer, and hope.

While in this city, a glorious cultural crossroads, we are celebrating the Forty-Fifth International Eucharistic Congress, in which the Holy Father, John Paul II, has also wished to take part, the Hospitaller Order of the St. John of God Brothers is commemorating the fiftieth anniversary of the hospital here which bears the name of their Founder.

Patients and health professionals and pastoral workers are the main actors in this celebration of ours today, whose peak is the Eucharistic assembly's encounter with the administration of the Sacrament of the Anointing of the Sick.

The real presence of Christ is, indeed, the presence of the Bread of Life and of Him who is the Physician of souls and bodies.

And we can truly witness to the authenticity of following Christ by seeing Him and serving Him in those suffering in body and in spirit.

Only when love and pain meet does man become a brother to man, and in this sublime solidarity we encounter God, the Author of the life that does not die.

The Hospitaller Order has been present in Seville almost since the years of its foundation. When, in 1943, the hospital was built in the Nervion quarter, the St. John of God Brothers wished to add another page to their continuous commitment to be close to the weakest and neediest.

The hospital in Seville's Nervion district arose to respond to the very serious threat of poliomyelitis impending over children, above all, fifty years ago.

Today this hospital is commemorating its five decades of life at a historic moment when, in so many parts of the world, it is once again children who are the victims of the gravest calamities.

Whereas from our heart there must flow a sentiment of profound gratitude for the immense, valuable work performed all over the world by the sons and Brothers of St. John of God, we commit ourselves to being close to them in the delicate as well as heroic fulfillment of their human and religious charism.

This celebration, which brings together a large healthcare family under the sign of hope coming to us from the Eucharist, is an opportunity to witness to the deep truth which the Holy Father, John Paul II, has included in the phrase "to do good with suffering, to do good to those who suffer." Under this twofold aspect, indeed, as the Pope reminds us, Christ has revealed to us the "in-depth" meaning of suffering.

The Eucharist is a gift to man of the Son of God, who, for our salvation and as the first fruits for all who believe in Him, accepted suffering to the point of the most atrocious death and then rose again to the life without end.

Christ is, indeed, the first fruit of the implementation in history of the mystery giving meaning to our lives, for He has taught us by his own life both to combat suffering and to give it the sole constructive meaning for each of us and all mankind.

I experience great joy on seeing that in all the activity of the Eucharistic Congress the sick occupy a predominant place, not only at this celebration, but also because I know that at the Eucharist which the Pope will celebrate next Sunday the sick will be present in large numbers and many others will be in communion with the Holy Father's Mass: the sick at hospitals and in their families.

Now I especially address those who will receive the Anointing of the Sick. First of all, I greet you and welcome those from Seville and those who have come from other parts of Spain, and foreigners, particularly some of you from Korea, Colombia, and Poland. May God, who is light, strength, and love, be with you.

The Sacrament of the Anointing of the Sick which we are celebrating is a gift, a gesture of love by God towards those who because of illness or old age feel weak. It is the visit of God to comfort, fortify, and help you. It is a deep encounter with Jesus, who is together with you today and says to you, "Courage, fear not; it is I." It is Jesus who immerses you in the pool to give you strength, energy, and grace, as the formula of the Sacrament states: "May He free you from sin, grant you salvation, and comfort you in infirmity."

The whole Christian community, and particularly the healthcare community, accompanies you and celebrates with you this strength, presence, and love of God.

This celebration of the Anointing of the Sick is taking place in the context of a Eucharistic Congress, and precisely during the celebration of the Eucharist, to signify that the encounter between the Eucharist and the world of suffering involves a profound relationship, as a mysterious moment of faith, hope, and charity.

It is a *moment of faith*. Like the blind man in the Gospel, we tell the Lord we have faith, but at the same time we implore Him to increase our faith.

For the suffering, faith is difficult, but it is the only source of real strength, of certainty

which does not deceive. For those who have chosen, in the name of Christ, to serve the suffering, faith is the reason for an increasingly intense and generous commitment.

The hospital whose fiftieth anniversary we are commemorating is a Catholic hospital. This does not mean it is a hospital which glories in or imposes a confessional label. The Catholic hospital is not different from other healthcare facilities; it simply aims to be more of a hospital than others, so to speak, in the sense that everyone admitted there or working there seeks to create in that environment the community of love which is the only effective response to pain.

For the Catholic hospital, the program and the spirit in which to implement it are described by Jesus Himself in the parable of the Good Samaritan, which the Pope loves to call the "Gospel of suffering." Dear brothers and sisters who serve the sick, measure yourselves every day against this sublime Gospel parable, which is the first and most exhaustive deontological code for health professionals.

The faith with which you seek to live out Christ's teaching will transform your condition and your service into a reason for great hope.

Today's celebration, indeed, is also a *moment of hope*.

Our society, so advanced and so restless, has an extreme need for hope.

At the beginning of his Pontificate, John Paul II asked the sick for the help, which he deemed indispensable, of their prayer and the offer of their suffering for the salvation of the world.

As salvation came from the cross, so only from the world of suffering and of service to the suffering can there rise up the truest and most trustworthy sign of and reason for hope.

The Church of Spain, with prophetic sensitivity, has for some time been fostering pastoral care in health in exemplary fashion. The world of suffering, for the communities of the Church in Spain, has for many years been the preferred field for apostolic action seeking the involvement of the sick and the members of their families in witnessing to its faith and its commitment to an ever-broader communion among men.

From the magisterium and ministry of suffering there comes the most credible lesson of hope in man and his resources and the noblest hymn to the dignity of the human person and the person's destiny. And the reason for this hope is rooted in the witness of charity.

We are now living out an intense and moving *moment of charity*.

The words we have heard in the biblical readings at this Eucharistic assembly have at their core the celebration of charity.

Through a providential grace of the Lord I have been able to devote my life as a priest and a bishop to a daily apostolate in the realm of health policy and care.

Every time, with sincerity and humility, I have sought to draw up a balance of this service of mine, I have observed that from this world of suffering and of service to the suffering I have received much more than I have given and attempted to give with all my strength.

According to the words of Christ, when we are judged on the authenticity of our witness to faith, we shall be asked what we have done to serve those who suffer. We shall be asked whether, in the least of our brothers, we have been able to recognize Christ, sick and persecuted, needy and abandoned.

Whoever suffers lives out the most universal and truest expression of the human condition.

Whoever serves the suffering fulfills the first and most serious duty of justice, which charity is called to support, nourish, and enrich through the manifestations of sensitivity, unity, and sharing.

Just as man is not known in depth and thoroughly unless his pain is known, so we are not fully brothers to one another unless we serve human pain.

The world is thirsty for love, and from the suffering there issues forth an imploring request for love.

In service to suffering, which is service to life, there lies the most fruitful terrain for an encounter among men, for faith in life and love of life are the prerogative uniting us all, regardless of our race, social position, culture, economic condition, political ideology, and even diversity in religious faith.

May the hospital celebrating its fiftieth anniversary today be the microcosm of a human community heralding a world of justice and charity, without which there cannot be peace.

May the moment of faith, hope, and charity we are living out and which we shall seek to turn into the inspiration for our thoughts and deeds find support and redeeming aid in Our Lady.

May the Mother of love and of sorrow, She who, as soon as She received the angel's announcement revealing to Her the mystery of the Incarnation effected in her womb, hastened to serve her relative Elizabeth, be our teacher of faith, hope, and charity.

From her motherly heart may She transmit to us love and a spirit of dedication: She who for centuries has always been invoked as the Health of the Sick.

Magisterium

Excerpts from Addresses by the Holy Father

Base Social Projects on the Gospel Law of Charity

On Sunday May 3 the Holy Father went to Udine's Casa dell'Immacolata, a home for disabled, destitute, or troubled young people founded in 1945 The home currently houses 87 people, but in its 47 years of activity it has helped over 8,000 children The founder, Fr Emilio De Roja, commonly referred to as "the saint of Udine" died on February 3 1993, exactly three months before the Pope's visit to his home.

Dear Brothers and Sisters,

1. My meeting with you today during my visit to the Dioceses of Friuli-Venezia Giulia has a particular significance since together with the social workers and numerous volunteers of the associations of Friuli who are dedicated to the service of the poor and needy, you represent the world of suffering and marginalization.

Together you present a panorama of the extensive charitable activities in the Diocese and the region, which includes, among others, communities that welcome children, young people, adults and the disabled; structures for social welfare and human development; groups of volunteers, cooperatives of solidarity, associations of families ready to accept abandoned children or those who come from difficult family situations; societies for recovering alcoholics, homes for newly arrived immigrants and refugees; continuing education centers for volunteers, and courses in formation and spirituality for those working with the poor and marginalized.

What you are doing is not merely intended as charitable activity, but above all as *an effort to teach solidarity, acceptance, and peace*, a commitment involving parishes and Church movements Indeed, in the wake of the document of the Italian Bishops, *Evangelizzazione e testimonianza della carità*, you are endeavoring to give priority to an apostolate of charity that focuses attention on the weakest, stimulating in all the components of the ecclesial community a sense of shared responsibility and the spirit of gratuitous service.

2. And then, how meaningful it is that our meeting should take place precisely here, in the "Casa dell'Immacolata" *founded by Fr Emilio De Roja*! He was a generous apostle of charity who died recently. Impassioned by love for his neighbor, this worthy priest always tried to offer help to anyone in distress As a solid and concrete witness to God's special love for the lowly, Fr De Roja committed himself to recreating a family for thousands of children from broken homes and opened his arms to prisoners, social outcasts, and abandoned children and adolescents Justifiably, therefore, he is considered an example of a "Good Samaritan" whose witness is inscribed in the long list of holy ones and heralds of Christ's love which has enriched the history of your communities: from the saintly Bishop Chromatius to Blessed Patriarch Bertrand, from Monsignor Francesco Tomadini, founder of the orphanage of the same name to Father Luigi Scoloppi, founder of the Institute for the Destitute in Udine and the Congregation of the Sisters of Providence, whom I myself had the pleasure of proclaiming "blessed."

3. In memory of your illustrious compatriots, I greet those of you present here, especially your Pastor, dear Archbishop Alfredo Battisti I greet those in charge and those who are employed in the "Casa dell'Immacolata," the volunteers and all those in Udine and throughout the region who dedicate themselves to the care of the suffering and the needy. But, above all, I greet you, dear residents of this center, to whom I wish to convey my affection. I embrace you all, expressing my spiritual closeness and I assure you that the Pope loves you because you are Christ's chosen ones.

To you the Lord has offered *a singular mission*: to make everyone aware *of the mysterious value of suffering* in God's plan of redemption. What often appears in the eyes of men to be of little account is, on the contrary, important in God's eyes and rich in merit. May you, therefore, be able to see your life as God sees it; ask him for the necessary light to understand his plans and the strength of heart to embrace his will. Our Heavenly Father will help you make your suffering a gift and a service to the Church for the salvation of the world Repeat often: "O God, be not far from me" (*Ps* 71:12), and again "In the Lord I take refuge" (*Ps* 11:11).

In Gethsemane and on Calvary, Jesus showed the depths of the scandal of pain and death, but he also performed an act of total abandonment into the hands of the Father, and thus suffering was linked to love

4. Beside every sick or alienated person, I see a friend or volunteer, and the words of the Psalmist come to my mind: "The Lord sustains the lowly" (*Ps* 147:6). Yes, the Lord makes himself the support of those who are tried, coming to their help through the availability of their brothers and sisters. And it is

when a person devotes himself to others with loving attention that he also succeeds in discovering the authentic meaning of his own existence.

Furthermore, can humans be fulfilled in any way other than sincere self-giving? Are not "Good Samaritans" perhaps those who carry out their own service to the suffering in an unselfish way, giving of their time and energy?

It is necessary to be "Good Samaritans" first and foremost within the family. Your tradition is characterized by the bonds of deep solidarity that have made domestic hearths warm and welcoming places, embracing families in a bond of mutual support. Do not let such a fruitful human heritage be lost! *Rediscover in the Gospel commandment of charity the basis of all your social projects*

The Gospel of charity will then be able to resound in this land of Friuli, thanks to the presence of people who in their suffering have totally abandoned themselves to Christ, and to men and women who can give themselves unreservedly to others, following the example of Jesus in the Eucharist.

Volunteers of all the associations and apostolic movements, attentive listening to the Word of Christ will make you the brave champions of the human being, of his or her supernatural dignity, of the life of every human person in the whole range of the person's natural development. Together, you will thus be able to contribute to changing our civilization into a civilization of love, opening yourselves to the dimensions of universal solidarity. Indeed, charity knows no bounds.

May the motherly protection of the Immaculate Conception sustain you on such a demanding journey of evangelical witness, and help you to keep this home and all your families ever open to welcoming your brothers and sisters in need, with inexhaustible faith in God and in humanity.

May my Blessing, which I gladly impart to those present and to all those who are united with us in spirit, go with you.

Base Medical Research on Choices with Ethical and Moral Value in Order Truly to Serve Life

The Holy Father's address to participants in the Neonatal Nephrology Congress organized by the Catholic University of the Sacred Heart in Rome, May 8, 1993

Dear Ladies and Gentlemen,

1. I am pleased to meet with all of you here today participating in the Fourth International Workshop of Neonatal Nephrology, and I sincerely thank Professor Luigi Cataldi for having briefly informed me on the objectives of your Meeting.

With my cordial greeting I express deep appreciation to the organizers of the Congress, to the members of the Scientific Committee, to the Chairpersons, to the moderators, to the speakers, to the scholars making up the research group, and to the relatives of children with renal pathology. These little patients are cared for with ever more promising results in specialized wards at the Agostino Gemelli Faculty of Medicine and Surgery of the Catholic University of the Sacred Heart, where your meeting is taking place, and also at other meritorious university and hospital facilities for health care.

I address a special welcome, in addition, to the distinguished scientists gathered together here from other European countries and from overseas.

2. Attention to the pathologies arising in the child's *perinatal and neonatal stages* is an indispensable requisite for medical research which truly serves man and is based on an ethical and moral choice of very lofty value. In this respect, it is significant that your sessions were opened with a paper on "Bioethics in Child Nephrology." Scientific knowledge certainly has specific laws which it is right and proper to abide by. But "science," as I stated in a similar context, is not the highest value, to which all others must be subordinated. Higher up on the scale of va-

lues is precisely the individual's personal right to physical and spiritual life, to psychic and functional integrity" (cf. *Allocution* to two Congresses on Medicine and Surgery, October 27, 1980, in *La Traccia*, 1980, p. 866/IX).

It escapes no one that the Church's and her Magisterium's concern is not expressed in the name of a particular competence in the domain of the experimental sciences, but rather to reaffirm the "priority of ethics over technology," the "primacy of the person over things," the "superiority of the spirit over matter" (cf. the Encyclical *Redemptor Hominis*, no. 16).

I therefore appreciate the strict methodological formulation of your sessions, since authentic scientific demands can only receive a positive and significant stimulus therefrom. The commitment of research to children's pathologies is an expert service to the human person at a decisive and uniquely fragile stage of development; as such, it constitutes worthy tribute by human intelligence to the mystery of life. "Human life is sacred because from its inception it involves the creative action of God and forever remains in a special relation with the Creator, its sole end" (Instruction *Donum Vitae*, Introduction, 5).

3 Quite often the painful and, unfortunately, widespread experience of renal insufficiency, even at a very young age, has roots which it is possible to diagnose as early as the prenatal and perinatal stage. The timeliness of diagnosis is an essential condition for suitable prevention. It is at the same time a priority basis to make possible therapies which are less painful and less burdensome for so many families affected by the serious problem of relatives with grave renal malformations. Thanks, indeed, to the fruitful work carried out by scientific societies and associations active in this field, in recent years there has been observed a consoling decrease in cases of chronic renal insufficiency among children.

The hard road of those under dialysis may begin in childhood, darkening a picture whose reflections in society are confirmed to be increasingly worrisome. It is, then, urgent to diminish further the number of nephrodialyzed children, in view of the extent of this pathology among adults. It is an illness which more than others touches families and, along with them, society, which is not always in a position to guarantee adequate instruments for care. All progress, however, requires, on everyone's part, increased awareness of the real seriousness of the situation, so as to implement a health policy fostering research and the involvement of ever more institutions serving life and its quality.

The Church is sensitive to these problems: a further sign of her attention is the fact that the upcoming Eighth International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers will have as its theme "The Child Is the Future of Society."

4 Distinguished Ladies and Gentlemen! The Catholic University of the Sacred Heart, which has for some years been organizing the Congress of the Study Group on Neonatal Nephrology, feels strongly committed to the field of prevention and treatment of renal malformations. The fact that this annual appointment coincides with the Fourth International Congress of Neonatal Nephrology confirms the importance of coordination and convergence among ongoing efforts everywhere in the world. And this occurs at a time when, much more than in other periods of history, a dangerous and discriminatory concept of health and its advancement is opening the way for temptations and even laws going against life and the person's dignity.

The seriousness of a malady, its human, personal, and social cost, and the disproportion between supply and demand, which sometimes renders hopes for a kidney transplant dramatic and vain, do not exempt science, as both research and practice, from the duty to multiply its efforts. Through initiatives such as your Congress, science is, on the contrary, called to sensitize public opinion and health officials so that achievements to serve life will be promoted and encouraged.

In the realm of this effort, which should involve everyone, your profession becomes a mission; your love for the young patients, an expression of authentic service to life; and the will not to surrender in the face of so many difficulties, an exemplary witness to human solidarity.

I thus convey to you, engaged in such a lofty task, my deeply-felt encouragement and gratitude. I accompany these sentiments with the assurance of my constant remembrance in prayer. I offer a special prayer to the Lord for the relatives of the young patients, that, by the intercession of Mary, Mother of God and of men, they may find the strength each day to overcome the painful trial they are going through, thanks to the support of Christian hope.

From the heart I bid you farewell with my blessing.

Give Young People Ethical Training

A new center for the training and continuing education of health-care personnel was inaugurated by the Holy Father during his visit to Caltanissetta on Monday, May 10. During his address, the Pope expressed his firm desire that the center may help the people of Sicily, southern Italy and developing countries, too, by creating jobs for the young and ultimately providing people with healthcare professionals having advanced technical skill and a deep Christian spirit

Dear Brothers and Sisters,

1. I am happy to be present at the inauguration of this large complex which will be used as a center for the professional training and continuing education of healthcare personnel. I cordially greet the President of the Sicilian Region, Dr. Giuseppe Campione, and thank him for the kind words of welcome he addressed to me. I also greet Professor Antonino Gullotti, who briefly told me about the goals of the "Society of Hygiene, Preventive Medicine, and Public Health Care," which organized the congress being held during these days, and Prof. Alessandro Hoffmann, whom I thank for his noble address informing me about the nature and purpose of this center. I greet the administrative, civil, and military authorities present and the directors of the local healthcare department, who, together with the local, provincial, and regional authorities, have sponsored this work.

I express a special greeting to the participants in the *Sicilian-Calabrian Convention* of the Italian Society of Hygiene, Preventive Medicine, and Public Health Care which is being held here. This meeting emphasizes an interesting characteristic of the new building in which we are meeting, situated almost at the center of Sicily and connected to the island's main cities by a good modern highway system; it will serve very well as a *place for meeting and dialogue*, benefiting primarily your region and the human and cultural growth of its people, and southern Italy in general. Considering Sicily's special location at the center of the Mediterranean area, it is safe to suppose that people of diverse cultures, languages, and religions located in the Mediterranean area will gather here.

Through its specific formation activity in the field of health care, this structure of yours can play an important part in *cooperating with developing nations*, particularly those of the Mediterranean basin and Africa. My cordial wish is that all this can help Sicily regain *its role as a bridge connecting diverse cultures and peoples*, a role which derives from its geographical position and its history as a crossroads for Western Europe, Southern Asia, and Islamic Africa.

2. The primary task of your center is doubtless of a *formative nature* and for this reason it has been supplied with lecture halls and laboratories furnished with the most advanced equipment. In its residence hall young people called to serve in healthcare, technical, and administrative roles in the public health departments of Sicily and the other regions of central Italy, as well as from developing countries, especially from the Mediterranean area and from Africa, will find lodging.

This place will be the seat of a branch of the public health department of the medical faculty of the University of Palermo, thus permitting many students to qualify in the specific field of hygiene and the practice of medicine.

The center will thus be a place for training young people as physicians, nurses, and technical and administrative workers healthcare facilities.

At the same time, it can help meet the *demand for jobs*, which affects the serenity of families and young people who, because of lack of work, are forced to leave their land or live in precarious conditions or economic instability.

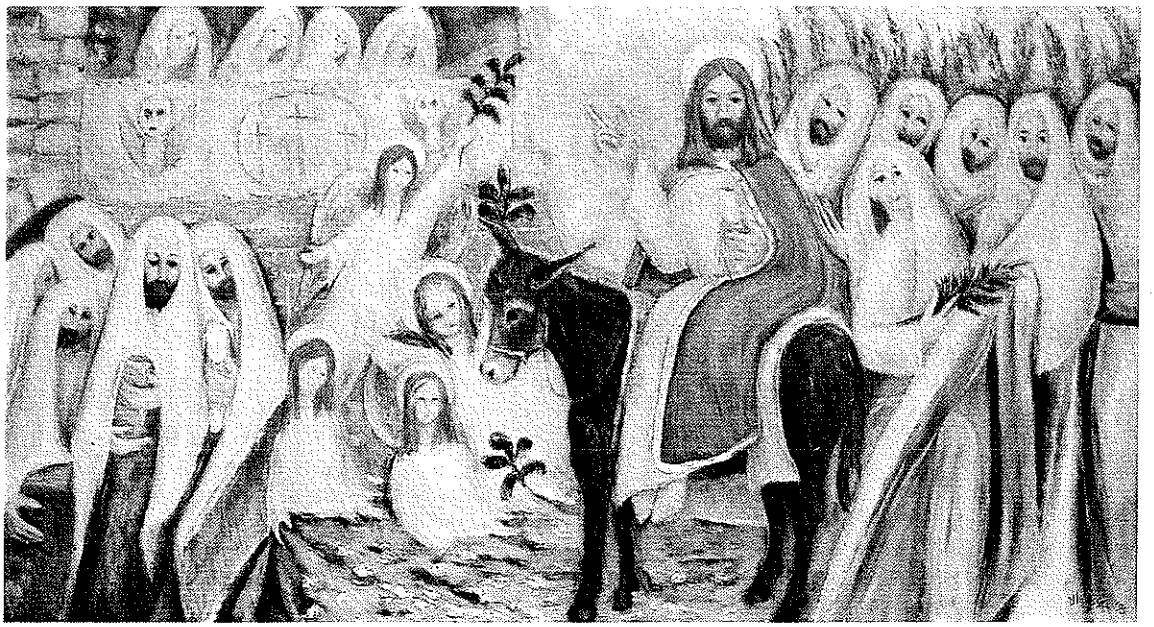
Credit, therefore, goes to the public authorities for having thus pursued a series of important related objectives of a cultural, social, and economic nature.

3. In particular, *two essential points* underline this project: *forming young people* and *serving the suffering*. It is more necessary than ever for young people to acquire not only technical skills but also a sound ethical orientation of service to mankind and the suffering. Preparing to work in such a field, therefore, is doubly formative, especially for the young: not only from a purely *professional* point of view, but more generally from a *moral and civil* standpoint. A society that invests in the healthcare field, and which does so by taking great care of the quality of its service and the expertise of the workers, is a society that chooses *an authentic degree of civilization*, for people's true welfare, which can never be reduced to the mere pursuit of material profit.

Following Christ's example, the Christian community "over the course of the centuries .. has felt strongly that service to the sick and suffering is an integral part of [its] mission" (*Dolentium Hominum*, no. 1). Therefore, it rejoices over every public and private initiative which benefits the suffering. In my Apostolic Letter on the Christian meaning of human suffering, I wrote: "At one and the same time Christ has taught man *to do good by his suffering* and *to do good to those who suffer* (*Salvifici Doloris*, no. 30). The sick person can "do good" by his suffering, living it in the light of the Gospel; all the faithful are called to "do good to those who suffer" through their charitable initiatives. The goals of the Caltanissetta training center, therefore, are visibly marked by human and Gospel ideals, by those ideals which have always had and can still have an important place in the culture and history of Sicily.

As I gladly encourage you in this new achievement of such great value for society, I to you all, reiterate the expression of my gratitude, with the wish that the many efforts that have been made may be rewarded with increasingly satisfying and fruitful results.

With that in mind, I cordially impart my Apostolic Blessing.



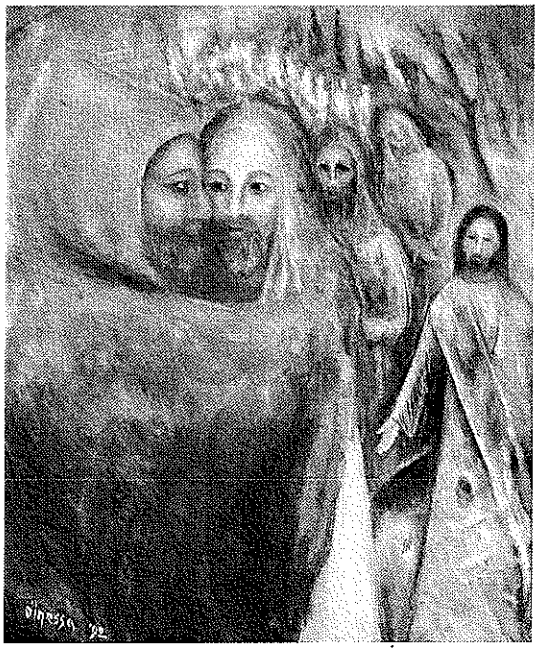
Enabling the Disabled to Live without Humiliating Forms of Charity and Vague Compassion

The Holy Father's address to the members of the International Research Center for the Self-Sufficiency of the Disabled received in an audience on May 14 1993

Dear Friends of the International Research Center for the Self-Sufficiency of the Disabled,

1. I cordially welcome all of you. I particularly greet Dr. Enzo Cassera and thank him for the kind words he has addressed to me on your behalf.

You have wished to pay me a visit to present to me the notable results obtained by your Center in the social advancement of the disabled. I am grateful to you for this sign of affection, which I am pleased to accept as an expression of the confidence deposited in the Church by the world of suffering. The ecclesial Community is spurred by its very announcement of the Gospel to place itself in the front line wherever witnessing to the concreteness and tenderness of God's love before our suffering brothers and sisters is concerned.



It is prompted towards this testimony not only by sentiments of human compassion, but also by its very love for Christ, who did not hesitate to say He was particularly present in those most needing attention, assistance, and love (cf. *Mt* 25:40). For this reason, among the varied activities organized by the Church, the pastoral care of the sick is especially meaningful. Precisely on the topic dear to you of "disabled persons in society," last November, through the initiative of the Pontifical Council for Pastoral Assistance to Health Care Workers, an International Conference was held in which numerous experts took part. There, the growing awareness of the national and international communities was observed regarding such delicate problems, and everyone drew from it a motive for new sensitivity and greater commitment.

2. "The quality of a society and of a civilization is measured by the respect it manifests towards the weakest of its members" ("From the Very Beginning": *Enchiridion Vaticanum* 7, 1145). This fundamental principle, which over ten years ago, on the occasion of the International Year of the Disabled, the Holy See enunciated in the framework of a special document, could be termed the criterion inspiring your singular effort in favor of those experiencing a state of disablement for the most varied reasons. This challenges social solidarity and, with greater reason, Christian conscience.

In this perspective, today's encounter with you is especially gratifying for me. It provides an occasion to bring out a *positive and enriching* approach to the disabled, to help them integrate themselves fully into civil society and into economic processes as well.

Unfortunately, it must be recognized that sometimes the hectic pace of modern life does not make attention to those living in a state of physical or psychic disability easy. Notable progress in this regard has certainly been made in public sensitivity and in the legislation of different countries. In not a few cases, however, if people do not close themselves in indifference to brothers and sisters bearing a disability, they are content with sterile forms of commiseration which risk making the disabled's condition more painful and intolerable.

3. Your International Research Center, which adopts an approach to the disabled utterly foreign to humiliating forms of charity and vague compassion, is, then, meritorious.

You rightly start from the assumption that they can offer society much more than what is impeded to them, provided the community

really makes room for their potentialities, which are generally latent and must thus be identified, cultivated, and wisely oriented. Your objective, which is truly praiseworthy, remains that of allowing the disabled to lead a "real life," as the motto of the prize instituted by you states, a life in which they not only do not feel like a burden, but can see themselves as useful and, indeed, playing a decisive role.

What you are doing, dear friends, is truly an expression of enlightened solidarity. Animated by sentiments of self-donation and profound dedication, it becomes one of the highest forms of Christian charity.

Continue to travel this road with perseverance. I am close to you with my affection and my prayer and am pleased to impart my Blessing to you, to the people you serve, and to all your loved ones.

A Generous Mobilization to Assist Life and Create a Culture of Life

Message from the Holy Father to the Dioceses of Lombardy for the Regional Meeting on the topic "To Be Born and to Die Today" May 15, 1993.

I address my most affectionate greeting, with the words of the Risen One, "Peace be with you," to you, dear brothers and sisters of the Dioceses of Lombardy gathered together in a solemn celebration at the close of the Regional Meeting on the topic "To Be Born and to Die Today." May the peace of Christ be with you, brother Bishops, and with you, priests, men and women religious, and faithful of the Churches of Lombardy. I bear all of you in my heart, also because of my contacts with you in my pastoral visits.

In this time after Easter the liturgy has us meditate on the words of the Lord: "I am the First and the Last and the Living One. I was dead, but now I live forever and have power over death and Hades" (*Rv* 1:17-18) *It is this presence which qualifies and gives value to your concluding meeting. You have walked for over a year along the paths of reflection on birth and death*: the two fundamental experiences of human existence find their full, decisive meaning in the Lord Jesus; in Him, "Alpha and Omega," the new life of the believer is innervated and interwoven.

You wish to announce to one another the deep meaning of living in Christ, the meaning of birth and death: allow me, too, to join in this announcement to the world and to express with you deep wonder at every child entering existence. Allow me to pause especially with you that are ill, share with you the suffering redeemed by the Crucified One, and thank you for the courage you show in your trials, for the fact that you recognize in the Lord the source of a life which goes beyond the gift of physical life, marvelous as it is. Allow me to join with you, young people; allow me to read in your gazes your passion for a life laden with prospects and projects, rooted in Christ and in his impetus of love for the Father and for his brothers and sisters; allow me to exhort you not to close your existence in disconnected, fleeting instants, not to waste time and energies traveling through useless or harmful labyrinths. I am with all of you filling the stadium of St. Siro in Milan.

My thought cannot fail to hasten to the history of charity which, over the course of the centuries, starting precisely from a deep love for life, has become interwoven with the varied components of civil and social life in your region.

And I cannot neglect thanking the Lord for the characteristics of ingenious creativity which have marked charity in your region over time.

It is also consoling to observe that today as well there is not lacking in your Churches a generous mobilization to assist life, to welcome it at the moment of birth, and to form a culture of life even within the anguish of death tragically marking wealth, when wealth turns into selfishness. With decision, constancy, and firmness you have moved in this direction, helping and supporting wherever life does not find means and resources to be worthily received. Charity has thus become solidarity, particularly in favor of those suffering on account of the varied forms of marginalization present in our time.

I offer my prayer to the Spirit of Life, who is the Spirit of charity, that He may increasingly strengthen in your Churches the sense of love which gives human life value and dignity.

May Our Lady, whom I had the joy of venerating at the Caravaggio sanctuary, suggest to each and every one of you the attentive, merciful love which is necessary in order for an authentic culture of life to affirm itself.

With these wishes in my heart, I embrace all of you in the Risen Lord and impart to all my special Blessing.

Topics

The Rights of the Terminally Ill Person

The Catechism of the Catholic Church and the Disabled

The Disabled Person and the Family

Nursing: Patient-Centered Care

The Rights of the Terminally Ill Person

"The movement for palliative care can contribute to medical practice's recovering a sense of the human."

— Neil MacDonald World Health Forum World Health Organization

INTRODUCTION

A group of health professionals, members of the Catalonian-Balearic Society for Palliative Care, have drafted *The Rights of the Terminally Ill Person*.

It is true that there is now great sensitivity as regards the rights of the human person, but, in spite of the high degree of sensitivity to and recognition of these rights, it is also true that this fact does not guarantee that these rights will be respected in daily practice

The Rights of the Terminally Ill Person are fundamental rights of the human being Therefore, if they are already an exigency throughout a person's life, they cannot cease to be such when the person reaches a terminal phase, but, rather, they should, insofar as possible, be consolidated in that situation

We reiterate that persons at that point in life have certain rights because of the very fact that they are persons, by their very nature, and that they must maintain the dignity corresponding to them as such, even in their physical decline These rights are not, therefore, a generous concession of civil society, which, on the contrary, must protect and guarantee them because they are intrinsic to every human person

Social structures condition the realization of human rights An unjust social structure not only would be unfavorable to the development of human rights, but would obstruct and turn them into an instrument to oppress the weakest and neediest

Some are convinced that it is risky to speak of rights: a risk consisting of presenting expectations which are excellent in theory, but unrealizable in practice and thus lead inevitably to disappointment and frustration

Of course, this risk exists. The very notion of "right" implies a rather partial and personalistic perception: in claiming one's own rights as a person—something quite legitimate, moreover—man may enclose himself within himself and forget the rights of others who—as needs to be said—also require attention and respect Unfortunately, we all know people who are always speaking about *their rights* and therefore act aggressively, selfishly, and unharmoniously in relation to others

Many health professionals do not look favorably upon formulating the legitimate requirements of the sick from the standpoint of rights—they prefer to speak of *needs* The reason they give is that, whereas in the world of work the union of forces originating from a single consciousness of individual rights may suffice to claim those rights, the sick person instead finds himself in a position of weakness and absolute dependence on institutions and health professionals

This kind of aversion to speaking of rights may also appear because, when we speak of them, we usually speak abstractly, in an ideal context separated from the experience of real people, or because we consider them from a strictly legal standpoint, far from the human warmth people seek in their relationships

While recognizing overtones which are probably utopian in this paper, we cannot deny the serious effort involved in translating into the language of rights the needs of the person in a terminal state. This was the aim of a group of health professionals in the Catalonian-Balearic Society for Palliative Care; they have sought to do so on the basis of their reflection and daily practice and now offer us the result of their work, as clear and precise as possible

We have not invented any right, but merely observed their existence Now, in order for these rights not to be perceived as merely a *moral value*, it is necessary for the positive laws of the State to safeguard and protect them with decision and effectiveness If not, they could easily be violated with the false excuse that they are solely a matter of aspirations, utopias, and good intentions

Furthermore, it must be borne in mind that a solemn declaration of the *rights of the terminally ill*, though deserving our respect, does not encompass all the needs of patients and their families

The human person stands above all categorization and transcends all definitions and declarations, even if utterly incontrovertible Each person aspires to getting certain problems—his or her own—solved How can we provide an adequate response to these problems? By simply paying close attention to the specific situation unrepeatably experienced by each patient And this demands real *humanity* in medicine Technology and scientific advances can never signify in practice an exclusivistic option closing the way to the humanism which has always been the glory and honor of medicine This is the responsibility not only of health professionals, but also of each and every citizen Every right is implicitly accompanied by a duty

We once more insist that it is necessary to descend from the world of ideas and knowledge to situate ourselves in tangible, effective achievements involving the terminally ill Kierkegaard reminds us of this fact when he affirms that the fundamental values—rights, for example—can be known and appreciated as abstract, universal concepts, but they must be lived out in personal, concrete reality

Let us make a declaration of rights, but let us not fall into the naiveté of believing that the mere formulation of them will automatically generate their acceptance and, even less, their application. We cannot, therefore, remain at ease repeating theories if they are not echoed in the social milieu.

I shall adopt the words which the Director General of UNESCO pronounced forty years ago: "As long as a single right of a single man can be violated with impunity, the Declaration of the United Nations will accuse us of cowardliness and sloth and will remind us:

— that we lack a shared sense of humanity;

— that each of the *rights of the terminally ill*, each line, condemns resignation, and each word forces us to examine our current healthcare situation."

I am certain that these rights will be applied as hoped, though perhaps with a century-long delay. But, undoubtedly, when that day arrives, new horizons and perspectives will be opened in the contemporary generations because they will feel dissatisfied with this long delay.

And the result of such dissatisfaction will surely be a new push forward

We accept that all of this is a utopia, and it certainly is, just as a century ago the right to health care or the heart transplant was The pseudo-realists must be reminded that utopia forms part of reality, that it is a premature truth, and that all necessary efforts must be made so that it will become a complete actuality. Fortunately, we can count on the verifiable and quite positive experience of many health professionals and facilities reinforcing the humanitarian attention we desire for terminally ill patients. This attention is required of us, for both they and we are human beings.

FRANCISCO SOLA
Catalonian-Balearic Society for Palliative Care

THE RIGHTS OF DYING PATIENTS

1. To Be Treated as a Human Person until the End of Life

Man, simply because he exists, possesses dignity as the only being with inherent value and not just as a means. Equal and reciprocal respect for human dignity, the basis for community life, is not something conferred on the person from outside or granted to him by society. It is a special, singular value belonging to him because he is endowed with intelligence and freedom and, consequently, deserves everyone's respect. This principle is familiar to the Universal Declaration of Human Rights, which in Article One establishes:

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and must act in a fraternal spirit towards one another.

This human dignity, which deserves full respect, is neither diminished nor lost as a result of illness. Every health professional must therefore share in genuine training to safeguard the person's dignity with the maximum respect, together with the team providing care

The patient's acknowledged preeminence requires that attention be paid to all his human problems—that preeminence cannot be displaced as something lacking importance. Attention to the physical, psychological, social, and spiritual needs of the terminally ill demands of health professionals that the quality of care be the result of technical competence and human sensibility To this end it is necessary and appropriate for the healthcare team for the terminally ill to be interdisciplinary in character.

The health professional must facilitate for the terminally ill person all that will contribute to his physical and moral well-being and foster humanity in care under two aspects: technology/science and relationships. In this way the patient will never be treated just as a means whose destiny is to achieve an end

2. To Receive Personalized Care

Each person is unrepeatable and unique and responds with his own style to the vicissitudes of existence and life crises. The human being, while endowed with freedom, is, however, conditioned by a series of circumstances: lineage, age, personal biography, sociocultural background, beliefs, etc. It is on the level of feelings where man faces illness and the problem of death. At this time personality traits which may appear masked in other situations display themselves differently.

Every human being reacts with a certain fear to disability, diminished capacities, sometimes humiliating dependence, loneliness, and uncertainty as to the manner and time of death. The team assisting the terminally ill must be alert to the hidden or manifest signs by which the patient displays his fears so as to provide him with consolation or companionship, an encouraging word, without frivolity, or respectful silence, listening carefully to one who at a given moment wishes to encounter a friendly presence offering him the chance to communicate at a certain degree of depth.

The members of the healthcare team must be able to recognize the defense mechanisms

which the patient brings into play to deny reality or cope with it.

When illness takes root in the individual and becomes chronic and the patient's state worsens, the hope of a cure gradually yields to the hope of being able to prolong life, if it can be lived with a certain degree of human quality. At the moment the sick person intuits or knows that the end is approaching, he maintains the hope of bearing it with dignity and wishes to preserve self- awareness, not lose reason, not provoke repulsion in others, see to it that his loved ones will not suffer or be in need in the future.

The patient has a right to be treated in his singularity as a person and not be reduced to a statistic. He has a right to have his hopes reinforced without deceit and, above all, to the assurance that he will not be abandoned, but taken care of physically, psychologically, socially, and spiritually, with all needed assistance both at the hospital and in primary care services. The healthcare team should allow the patient to manifest or conceal his fears and help him to overcome and accept the real situation according to his capacity and maturity.

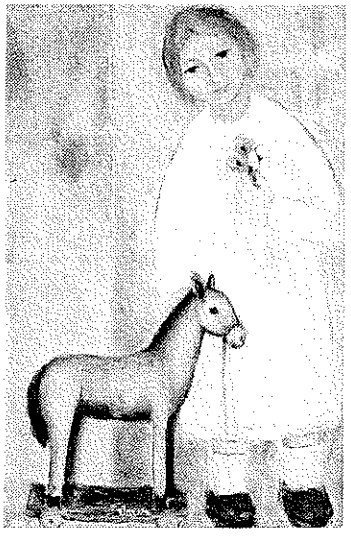
3. To Take Part in the Decisions Affecting the Care Provided

In this right the patient's autonomy as a human person is defended; as a person he has the right to freedom and not to be coerced for any rason. This right may present itself under its positive or negative aspects; the former—as mentioned in our statement—presuppose greater maturity on the part of the patient and the healthcare team and are rooted in the duty to provide accurate and sufficiently understandable information.

The aspect we might call "negative" is the patient's right to refuse a certain treatment. We must stress that this right does not amount to the right to attempt on one's life with the help of the doctor or nurses or to subjective impulse or to turning physicians into automatons at patients' orders. The patient's right refers to being able to refuse treatment when a certain therapy or medical action may reduce his quality of life to a degree incompatible with his dignity or prove excessively burdensome for him. This right includes sufficient, truthful information, and explicit consent by the patient or his legal representatives, when involved (it is supported by the Spanish General Health Law of 1986, which affirms the right to refuse treatment—unless this refusal produces harm to society—and the right to choose among the different therapeutic options proposed [Articles 9 and 6, respectively]). In Catalonia these ideas have been incorporated into the *Rights of the Patient as Client of the Hospital* (cf. Articles 10 and 12), whose legal underpinning is in the corresponding Accreditation Orders (April 25, 1983 and July 10, 1991).

The terminally ill still have a capacity for greater fullness in being, in spite of their limitations. If the patient is capable of self-government, his desires concerning visits, comfort, and psychological and spiritual attention must be respected to the utmost.

It is important to discuss plans for care with the patient,



or, if this is not possible, with the family, in an effort to respect tendencies, habits, and wishes shaping his identity as far as possible, provided they do not adversely affect others.

The *Rights of the Patient as Client of the Hospital* established by Catalonia's Generalitat [regional government] sets forth the question we are considering as follows:

The information supplied should give the patient sufficient elements for judgment to be able to participate actively and responsibly in the decisions affecting him. The patient must feel he is an integral part of his own process (Art. 7.2).

The patient shall also be given advance notice and informed, and must give his consent, before certain explorations are effected which by their nature may affect the individual's privacy, sensitivity, or modesty (Art. 7.2b).

4. The Necessary Means to Combat Pain Must Be Applied

The health professional must always strive to ease the patient's suffering insofar as required.

Pain is a twofold phenomenon: one part is the perception of sensation; the other is the emotional reaction aroused in the patient. It is necessary to pay attention to the nonpharmacological factors modulating the pain threshold. The most appropriate strategy for the treatment of pain is to conceive of an integral approach to the patient under all aspects: physical, psychic, social, and spiritual.

The pharmacological treatment of pain will be adjusted individually, in terms of pain's causes, intensity, and duration, with periodic evaluations, so that the patient will enjoy the greatest possible degree of well-being.

In the terminally ill with serious chronic pain the potential risk of addiction to opiates is irrelevant in selecting an analgesic therapy.

The health professional should do his best to prevent analgesic therapy from unnecessarily provoking a loss of consciousness in the patient.

5. To Receive Appropriate and Honest Answers to His Questions, with All the Information He Can Accept and Assimilate

When we consider the aspects related to information and communication in the situation we are examining—that of the terminally ill patient—we see that it is a difficult subject in practice.

In this situation information encounters difficulties, on the one hand, because bad news —basically concerning death— has to be conveyed and, on the other, because of the complexity of the elements comprising the situation (patient, family, and healthcare team).

It must be stressed that dying is a personal, intimate event belonging to the ill, just as their lives belong to them. The patient is not a problem separable from his personhood, life history, and surroundings. It is his whole self that needs help and calls for an individualized interpersonal relationship with someone who is, of course, scientifically trained, but who also assumes responsibility for the global difficulties of the ill.

The healthcare team will be adequate if capable of coping with the situation and willing to provide opportune aid. The problem of the sick—to feel unwell—means anguish, fear, many questions, and the need to communicate this state as well.

When we attempt to deal with care for the terminally ill, we realize that the problems arising often transcend their illness. All the people around them are in fact affected, the family and also the healthcare team.

The team may experience a feeling of failure, impotence, and lack of knowledge. Rather frequently it opts to keep the family informed while depriving the subject of this right, who is the patient, of such information. A certain conspiracy of silence enwraps the patient at the most difficult and critical moments. The patient may accept the situation or, on the contrary, rebel or show resentment or aggressiveness.

The healthcare team must reflect on the following points, among others:

— The relationship with the patient: adult or infantile;

— Respect for the patient's right to be informed (lying is inadmissible);

— The degree of communication and an attitude of listening and respect;

— The quality of information: gradual, understandable, continued, and truthful;

— The degree of peace and personal serenity in communication, so that the patient's tension and anguish will not increase.

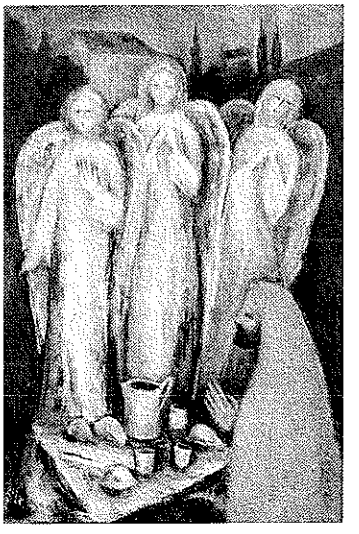
The manner in which the family can be brought to participate adequately, if appropriate for the patient, must be considered. We must avoid the mistake of thinking that information is a matter of precision. In reality, it is an entire process including support for the patient in the course of possible changes in the illness and in treatment.

6. To Maintain a Personal Scale of Values and Not Be Discriminated Against Because One's Decisions May Be Different from Those of Care Providers

Intimately linked to the concept of dignity is awareness of oneself and of the values which have given meaning to one's existence. The person as a moral agent has an awareness which is the final reference point in decisions on moral values. No one can take the place of this conscientious decision in the adult, conscious person, and no one has the right to coerce, either openly or secretly.

If the technical, diagnostic, and prognostic dimension belongs to medicine, the perception of what is good or bad for the person, and, in the final analysis, the quality of life, corresponds to the patient. He should listen to the explanations he is given. The doctor and healthcare team must have assurance of a sufficient degree of comprehension, but only the patient can say whether he dares to give meaning to his existence with a certain quality of life or dares to face up to the burdens entailed by a given therapy with the help offered him.

It should be recalled that, although no one has the right to impose his criterion on the life of another against the latter's will, no one has the right to discriminate against a patient either because he has chosen a therapeutic option not to the liking of



the doctor or the healthcare team

In any event, the health professional has the right to conscientious objection when the patient's attitude or decision is contrary to his ethical principles In that case he will refer the patient to a colleague or an institution, with the previous agreement of the parties, always maintaining the maximum respect for the personhood of the patient

7. To Maintain and Express Faith

Starting from religious freedom and freedom of conscience, and with the will to offer each sick person integral care, we must attend to spiritual needs

Perception of and assuming responsibility for these needs facilitate understanding of the person and help him to find the serenity and peace offered by beliefs or philosophical convictions giving meaning to life.

Healthcare facilities must have adequate means available, both human and material, to respond to spiritual needs. Pastoral services, integrated into the hospital and collaborating with other professionals, can help to accompany sick people at critical moments when support is needed

This attention, which is always important, can help the terminally ill in particular to take stock of their lives and frequently rediscover the inner peace enabling them to cope with their experience

Sensitivity and respect for beliefs and philosophical convictions foster the relationship of different professionals with the sick and promote trust Especially at the final stage of life, the sick need comprehension which liberates and allows them to see life with confidence and hope

The ill need to heal the wounds deriving from their personal histories, find meaning for life in this situation of suffering, reconcile themselves, feel accepted and accept themselves, and take on the losses succeeding each other throughout a lifetime

The healthcare team must know the patient's religious and ethical beliefs which may influence medical decisions It is quite important to know how the patient perceives life and death The people who are at peace with themselves and accept death are more likely to express their real preferences

When possible, the health professional must get the patient to discuss these preferences with the members of his family The objective is for the family to feel comfortable with decisions When the patient dies, the family remains and must be capable of living with the circumstances surrounding the death of their loved one

8. To Be Treated by Competent Professionals with Communications Skills Who Can Help Patients Face Death

Above all, the healthcare team for the terminally ill must have human sensitivity: a capacity to listen, assimilate, and speak of the problem without fear of commenting on limit situations which are highly charged emotionally Its attitudes cannot be rigid, inflexible, or authoritarian Personnel must be carefully selected and should receive progressive training and qualifications Group meetings, discussing cases, psychological guidance, care planning, and good organization are essential elements

The personal state of the members of the healthcare team cannot be overlooked The emotional burden connected with follow-up of the terminally ill has repercussions on the private life of team members They need attention—to neglect this would be a serious mistake

The human quality of a hospital depends on the relations between patients and health professionals and on those of the latter with one another As in every human relationship, there are difficult and critical moments for one member or the whole team. The team relationship includes an element of group therapy, whenever needed It sometimes happens that one or several of the team members themselves may be hindered by their feelings or problems, making it harder to relate to the patient at a given point

To help the patient cope with death also means the capacity to face up to one's own death and limitations, or "passivities," to use the language of Teilhard de Chardin

In this way one gradually acquires the maturity and serenity required by verbal and nonverbal communication with the terminally ill Verbal communication means sensitivity so as never to give bad news in a brutal manner; it demands intelligible language which the patient can understand; it must offer help by solving problems worrying the patient or making possible adjustment to a loss Communication should be open in character; i.e, it ought to avoid bruising, rigid phrasing, enabling people to speak of the situation without thereby implying an irrefutable condemnation

The components of nonverbal communication are:

— *space*, in an appropriate place, tranquil and comfortable, for communication to occur;

— *listening*, marked by an attitude of interest, without displaying distraction or hurry;

— *affection*, with the sharing of feelings;

— *drawing near*, by sitting beside someone, looking in that person's eyes, using physical contact as a nonverbal form which is basic to communicate security and well-being to the patient

Death is the same for all, but we do not all situate ourselves in the same way in the face of it No two people die alike

A limit situation permits a coming to awareness posing anew the meaning of life A prolonged illness changing our vital rhythm and causing us to feel diminished makes us realize that finitude is not an idea and that death may be close to us

Feelings of depression, anguish, fear, isolation, frustration, abandonment, and uselessness always accompany to some degree the patient with a fatal diagnosis

To allow the patient to express the feelings oppressing and threatening him is to help him to accept his real situation and to accompany him at the decisive moment

To allow him to express his pain will make final acceptance easier of the moment when he will lose everything and the persons he loves.

Negative feelings become aggravated with isolation and lack of communication, and to help him to express them in a respectful climate will undoubtedly relieve the patient in all instances.

9. To Receive the Consolation of Family and Friends He Wishes to Accompany Him Throughout the Process of His Illness and at the Moment of Death

Death evidently has an individual, personal dimension. We die alone, and each dies his own death. But this individual facing up to death must not be confused with isolation. The terminally ill may legitimately ask not to be bothered, *but no one wants to die rejected by others*. Noises, laughs, and voices should be avoided, but systematic isolation is not recommendable.

The fact of being surrounded by loved ones, with greater communication among them and more frequent information for the family from the healthcare team on the patient's state and symptoms, makes death more *normal*.

The deeply humane quality of the relationship between the healthcare team and the patient must also be reinforced to the utmost. The intimate and inevitable solitude of the dying can be more bearable as a result of the human warmth of those providing care.

When human, psychological, and, for the believer, religious aid is offered, the encounter with the truth of death proves highly positive.

Patient and family should be regarded as a unit to be treated by the healthcare team. Family and patient should, ideally, help one another. The healthcare team ought to assist family members and friends to maintain an open, trustful posture. A lack of serenity in the family increases the chances that the patient, too, will not be serene.

In order for the patient to receive aid and consolation it is appropriate for the healthcare team:

— to make itself available to both patient and family, choosing a tranquil, unhurried place to sit and speak of the topic with naturalness and without dramatizing, whenever they wish;

— to clarify doubts on the patient's evolution and treatment, feelings of fear, uncertainty, depression, anxiety, or loneliness;

— to make decisions on therapy with the patient and the family, when possible;

— to react in time to the patient's and family's need for spiritual support;

— to take into account the actual context of the family and identify the spiritual and emotional resources of both patient and family so as to provide support to the former;

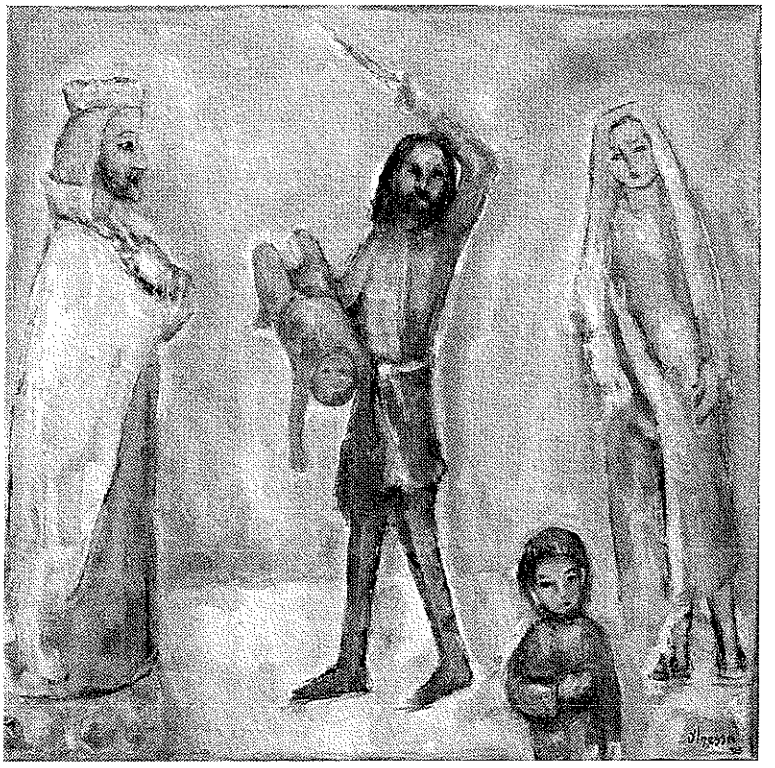
— to facilitate the patient's relations with relatives and friends, making suggestions on how they can communicate with and accompany him;

— to stress to family members the importance of their presence alongside the patient and instruct them on the tasks connected with care, reinforcing the family's role in therapy to the utmost.

Relatives usually feel better if they can do something; our objective will be to integrate them into the process to the maximum degree so that the patient will reach life's end accompanied in every respect.

10. To Die in Peace and with Dignity

At the most human time in life, which, paradoxically, is that of death, the person needs affection and companionship, with recognition of the right of die in dignity, understood to be a rejection of a forced, exceptional arrangement of existence. *Use-*



less, obstinate forms of care can even become inhuman and cruel when, against the individual's and the family's will, experimental tests are carried out on the dying.

The patient ought to die in a family environment, if possible; if not, death should take place in surroundings which most resemble the home.

Every man has the right to live through his own death. It is his last chance to exercise his own freedom. This freedom must be respected by the healthcare team, relatives, and the hospital itself.

Death in peace proves more dignified when the patient undergoes death with lucidity, not repressing anguish, but overcoming it through dialogue and sincere communication giving him reconciliation, peace, and inner harmony.

11. After Death the Body Should Be Treated with Respect

12. The family must be correctly informed about the circumstances of death and receive administrative, psychological, and spiritual help to cope serenely with the period following death

— In the event of autopsy, organ donation, or even the consignment of the body for research, it should be treated with respect.

— The terminal phase is a particularly difficult time for the family at which the defense mechanisms it has developed are called into question.

— The family has a right to be present in the final moments and to have time to say goodbye so as to avoid negative feelings which would obstruct the unfolding of mourning (e.g., anxiety or resentment over not having been able to see or touch their loved one).

— The family has a right to be helped administratively (e.g., with transfers) so that greater anxiety will not be added as a result of disorientation at that difficult time.

— When the outcome takes place, the family has a right to correct information from the healthcare team about the situation prior to death.

— The family has a right to ensure that the body is conserved in a dignified place before burial.

— After the death the family has a right to be helped to undergo mourning and to express its own feelings so as to be able to accept the real loss.

— The seriousness of their affliction is related to the intensity of their interaction with the deceased and the latter's role in their lives; as a result, violent imbalances are sometimes observed on the part of family members.

— Relatives sometimes experience feelings involving emptiness, uselessness, despair, anxiety, insomnia, tension, tiredness, irritability, worry, etc.

— The family should be supported so as to express its intense and confused feelings, which may be laden with remorse over imperfections in their relationship to the person (e.g., incomprehension and misunderstandings).

— The effects of distress begin to lose intensity in the first six weeks after death, and most relatives recover after several months; but some of them manifest atypical forms of sorrow which can seriously incapacitate them for the demands of social life; as a result, they must be assisted and helped to form new relationships and adapt to a new situation, which on occasion brings with it a radical change in their daily routine.

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The Role of Catechesis for the Disabled in the *Catechism of the Catholic Church*

Analysis and Prospects

It is commonly said that disability in itself constitutes a continent populated by 500 million people [1]—a continent cutting across frontiers which is not linked to territory

It is not common, however, to hear it proclaimed that within this continent there occur events, there are mental changes, suggestive attitudes are adopted, and original results are obtained through which a course of renewal of the social life of all the peoples on earth is beginning to be traced

On this continent we observe the conscious convergence of men of every race, religion, culture, and political tendency who compare, compete and find themselves united in the need for effective, and at once stimulating, support of reflection on the meaning of man in history. Public opinion perceives this phenomenon only in a fragmentary way and nearly always under the fragmentary aspect of a momentary and at the same time emotionally ephemeral echo.

Love and closeness to disability are, however, capable of provoking an innovative turn of events in social structures, from the standpoint of both bioscience and the enjoyment of the beauty of man's community life

Catholics, in particular, introduced to it by the saints' experience—of which their history is rich—enter this continent by becoming more and more willing to continue the words and deeds of Jesus Christ with greater community involvement: "A force came out of him that healed everyone" (*Lk* 6:19).

John Paul II has in fact discerned a path where it is possible to trace out the lines of autonomous and free growth for those who are disadvantaged "The family, the State, and the Church —the structures supporting human life in community—are asked to make a special contribution so that the culture of solidarity will develop and so that the disabled may become authentic and free protagonists in their existence." [2]

Indeed, in endorsing the message of the prelates meeting in a Special Assembly of the Synod of Bishops in 1987, he made an invitation summarizing the entire pre-eminent function of the disabled: "We are counting on you to teach the whole world what love is." [3]

Those Living in the World of Disability

Who are these people and how are they designated in this period? In reality, the greatest diversity in terms of both psychophysical discomfort and distribution in the population and in different social conditions sometimes makes a definition precarious.

We might perhaps agree on what Professor Tarlov of Tufts University in Boston, Massachusetts objectively stipulates: "The term 'disability' refers to limitations caused by one or more pathological conditions on physical or mental functions in carrying out socially defined roles and tasks which it is up to individuals to perform." [4]

In this definition we discern a disabling process "composed of four correlated stages: pathology, impairment, functional limitation, and invalidity" [5] The content of this definition is important for its characterization of the subjects referred to.

The terminological problem, on the other hand, appears more dialectical. The term "handicap," arising in the particularly refined sporting context of horse races, appeared in English-language literature to replace designations which somewhat distorted proper social relations. But even this term is now considered degrading in common usage, especially if applied to the group or class. " 'Handicap' is perceived as a negative, disparaging term in the United States and, along with the word 'lame,' is becoming obsolete " [6]

In another sense the term "disabled" is gaining ground, but the content is not always objectively appropriate, at least from a biomedical and social standpoint

In the current context of interpersonal relations, in an increasingly widespread process of integration, the personal name prevails, with one's Christian name.

In the sociomedical relation, the fragmented association of invalidity with different sectors is predominating

However, for our purposes, what matters is to go beyond the verbal designation and arrive at a discovery which will place the whole Christian community face to face with the real problem, taking up the objective responsibility of everyone

We can thus start from the manner in which John Paul II's focus of the Magisterium is being carried forward.

"You are members of the Body of Christ: the body of the Risen One This is the real foundation for an indestructible dignity A dignity withstanding even the defeat of death " [7]

It is from this standpoint that catechesis deals with the problem. There are handicapped people: cardinals and scientists, youths and adults, religious and lay people, children and the elderly, men and women. The perspective in which they are considered is that of physical, sensorial, and mental handicap

The catechistic approach, however, cannot be limited to lofty intellectual comprehension of the subject We would in fact come to discriminate against people with serious handicaps and consequently exclude members of that Body whose Head,

in the final hours of crucifixion, was burdened with a handicap through which He became salvation for the whole world. "Was it not necessary for the Christ to endure these sufferings in order to enter into his glory?" (*Lk* 24:26).

The announcement and the way of discipleship must be offered to all without distinction, though gradually and with proposals differentiated not only in terms of content, but also, and above all, in regard to the most specific methodologies.

The Place of the Disabled in the Catechism of the Catholic Church

A preliminary question must, indeed, be resolved at the outset. The Magisterium of the Church, after Vatican II, has taken up the word "handicap" as an adequate term to enter into communication with national and international institutions.

Statements by the Pope and the Roman Congregations have not hesitated to use this term. In the *Catechesis Tradendae* (Chapter V, no. 41), there is explicit mention of the handicapped: "They, like their contemporaries, have the right to know the 'mystery of faith.' The greater difficulties they encounter make their efforts and those of their educators even more meritorious."

In the *Catechism of the Catholic Church (CCC)* the terms "handicapped" or "disabled" recur, but not as a subject of catechesis. In no. 2248, we are indeed reminded of "physical and psychic infirmities." But in no. 2433 we find *handicapés* in the French and *disabili* in the Italian text. It is, however, a term taken from *Laborem Exercens* (IV, 22) regarding the subject of access to work.

This limitation does not mean that the corresponding problematic of handicap is not found in the text. The terms used are the traditional, vague ones, which, however, are not yet subject to semantic pollution: "infirm," "sick," "suffering."

Through these terms, though not univocal, the reference to the people who are today called physically, sensorially, and mentally handicapped is clear. It is, in any event, a terminology which is also found in the Gospels, the Fathers, the Roman Catechism, and the texts of Vatican II. The reason should perhaps be sought in the fact that the *CCC* is not a catechistic directory, nor can it be regarded as simply a catechesis, which, moreover, is a stage in evangelization and cannot be dissociated from the Church's pastoral and missionary initiatives as a whole (cf. *CT*, III, 18).

In addition, the *CCC*, in response to the 1985 Synod of Bishops, serves as a reference point for the catechisms and compendiums that are prepared in different countries (cf. *CCC*, 11).

It is then up to the Bishops, to those drafting catechisms, to priests, and to catechists to use it as an instrument to teach the People of God.

This reading is declared to be useful for individual Christians as well (cf. *CCC*, 12).

It is in this perspective that handicapped people are included for the specific purpose of constructing adequate catechisms. There truly is an anthropological formulation open to the mystery of Christ which could stimulate the drawing up of a text responding to the demands of all those living in the world of disability. It would be an enterprise worth attempting, in an effort to channel the forces of at least European catechists, with the collaboration of handicapped people. Let us recall C. Nolan in the novel, S. Hawking in science, Bianchi Porro in experiential reflections on spirituality, or Cardinal Andrzej Maria Deskur in the pastoral field. It could be an experience of comparison and contrast among all those writing national and diocesan catechisms.

Direct reading is not excluded for all the handicapped people who have the chance or for whom instruments being prepared by modern technology —which exceed even our fantasy—can be made available. I am particularly thinking of the physically or sensorially handicapped, for whom we should set to work on transcriptions of their languages—e.g., the sightless. As regards the blind, the future will introduce instruments arising from the scientific study of the neural networks. From this standpoint, audio instrumentation and Braille writing may soon be regarded as museum pieces.

Catherine of Sienna, when wishing to learn to read, after lack of success with one teacher, invoked the Lord's help and did learn to read, though in a global manner, as would be said today, for she was unable to analyze each syllable in a word.

I recall Yolanda, a girl who was deaf to all sounds and incapable of distinct pronunciation of any; with the Bliss language she was able to communicate the content of Catherine of Sienna's life.

An Anthropology Structured Around the Novelty of Jesus Christ

The *CCC* aims to respond to the demands of a social reality in the process of transformation. The constant of societal renewal runs the risk of losing reference to the basic presuppositions for man's "survival." This phenomenon threatens to involve the ecclesial experience as well. A growing culture, an expanding science, and an economic and political reality aiming at new ends threaten to annul awareness of Him who is the Alpha and Omega of history.

The Synod of Bishops' request in 1985 "that a catechism or compendium of all Catholic doctrine, as regards both faith and morality, be drafted" (cf. *CCC*, 10) arose from this context.

The *CCC* responds to this request by drawing inspiration from the great tradition of catechisms. It indeed rests upon four pillars: the profession of baptismal faith (the Symbol), the sacraments of faith, the life of faith (the commandments), and the prayer of the believer (the Our Father). The text contains a multiplicity of subjects intended to bring out the centrality of the mystery of Jesus Christ, towards whom everything preceding Him tends. The effort to explicate the new man —whose conclusion is found in the definitive Trinitarian relationship—starts from this core.

It would be restrictive to regard the content of the *CCC* as a

global system from which some doctrinal components should be removed to make possible access by the weak, especially the mentally limited Restriction is acceptable methodologically But the truth cannot be divided for anyone, also because it tends to construct charity.

"The whole substance of doctrine and teaching must be oriented towards the charity which will never end" (*The Roman Catechism*, 10)

The entire catechism, then, is for handicapped people

Within this "symphony," as John Paul II says, it is, however, possible to detect the song of novelty, which becomes explicit in the disabled person

It would be too lengthy to focus on the props upon the four pillars from which the disabled can draw the support which in pastoral and catechistic practice has often been denied them It will suffice to stress the elements constituting a new anthropology and delineating the origin, development, and meaning of the disabled person

1 *Liberation from the question on the origin and cause of handicap*

Many tensions in society —and in the Church, too—center on the search for responsibility The *CCC* asks this question (cf 309) and indicates the providential design of a creation on the way to perfection and the drama of the sin of angels and man, creatures richly endowed with intelligence and capable of free actions

In God's design there will be "physical evil" alongside "physical good" until creation reaches its perfection (cf 309) There is also moral evil, incommensurably greater than physical evil (cf. 311).

But all of this is in the perspective revealed to us by Paul: "Everything contributes to the good of those who love God" (*Rm* 8:28). Everything comes from love, St Catherine of Siena says; everything is ordered towards man's salvation—God does nothing except for this purpose (cf 313)

2. *The presentation of the beauty of the Word, who became man to save man*

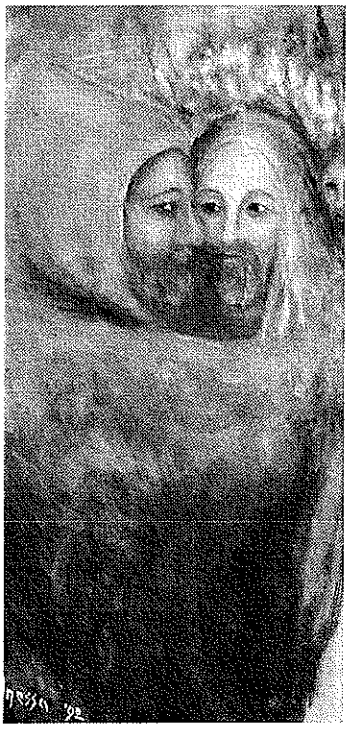
The origin of evil has no answer "unless we keep the gaze of our faith fixed only on Him who alone is the victor over it" (cf. *CCC*)

The presence of Jesus Christ is an event which unfolds and recapitulates the whole development of the *CCC*. The four pillars are the points from which a single edifice rises up whose cornerstone is Jesus Christ in his reality as a perfect Man, a God-Man The different ramifications of the whole text bring out the splendor of a Presence which attracts and fascinates

The words of Gregory of Nyssa are cited to summarize this event: "Our sick nature needed to be healed; decayed, it needed to be raised up again; and dead, it needed to be resurrected We had lost the possession of good; it was necessary for it to be restored to us The light had to be brought to us, immersed in darkness; lost, we awaited a savior; as prisoners, a helper; as slaves, a liberator" (cf. *CCC*, 457)

3 *Jesus Christ is the suffering servant of God who with his life becomes the paradigm for every man*

"The whole life of Christ was a continuous instruction: his silences, his miracles, his gestures, his prayer, his love for man, his predilection for the least and the poor, his acceptance of the total sacrifice of the cross for the redemption of the world, and his Resurrection are the implementation of the Word and the fulfillment of Revelation" (*CCC*, 561)



4 *The precise features of Jesus as the physician of souls and bodies and the life and death of Jesus are presented in the light of the Suffering Servant*

His service is inseparable from its application. He freely consigned Himself to death out of love for the Father and men But this offer of God's health to men is not unrelated to liberation from illnesses

"The Lord Jesus, physician of our souls and our bodies, he who forgave the sins of the paralytic and restored his bodily health, has wanted the Church to continue his work of healing and salvation with the force of the Holy Spirit" (cf *CCC*, 1421)

A doctor, then, in the face of a disabled person, can show the way towards physical healing, through the development of medical science as a continuation of his hands and therapeutic vigor, not excluding the possibility of miraculous healings as a prolongation of the signs of this mystery

But divine life is the full healing which the Divine Physician gives to all believers

5 *This complete healing of man is continued in the reality of the sacraments*

In truth, Jesus Christ cannot be relegated to the perimeter of his historical space He continues in his Church Sharing in divine nature is made possible for man through the sacraments "The faithful, reborn in holy Baptism, are authenticated by the sacrament of Confirmation and then nourished with the food of eternal life in the Eucharist, so that through the effect of these sacraments of Christian initiation they are capable of enjoying ever more and better the treasures of divine life and progressing to the attainment of the perfection of charity" (cf. *CCC* 1212)

Everyone is called to this divine life. The stipulations and

conditions are indicated by the Magisterium of the Church

The specific determinations for disabled people are not delineated, but are left open for the pastoral action of the Church, under the guidance and vigilance of the Magisterium

6 *The disabled are the members of his body who unite themselves to the sacrifice of Christ*

Sacramental life does not remove the temporal consequences of sin. The sufferings and illnesses remain. We are still in our earthly dwelling (*2 Co* 5:1), subjected to suffering and death. There is no contradiction between this suffering and the joyful announcement of liberation.

Men become collaborators of God with their sufferings as well (cf. 165, 307).

Catechistic Perspectives on a "Disadvantaged State"

These constituent elements spur us towards further reflection. Perhaps useless attempts at reduction can be eliminated from catechesis for the disabled and a paradigm can indeed be constructed which will illuminate all the catechistic action by the Church.

The blood shed in Bolsena on the corporal and conserved in the cathedral is the energy which has coagulated faith over time and prompted the creative artistic power abounding in the beauty of the architecture and excellent paintings in this stupendous church.

Can the suffering members of the Body of Christ constitute the energy for a catechesis shining in the pastoral action of the Church in our time?

In truth all authentically evangelical catechesis free from vaguely ideological biases represents an inseparable bond between "words and deeds."

The intrinsic relation between being and communication spurs us not to regard an event as incapable of speaking and the word as separable from being.

It is possible to make Christ resound in our time provided we live in Him. "We must agree to lose everything so as to gain Christ and be found in Him and know Him, the power of his Resurrection, sharing in his sufferings, becoming like Him in death, in the hope of arriving at the resurrection of the dead" (cf. *CCC* 428).

Paul VI regarded disabled persons as the continuation of Jesus' passion and crucifixion in the Church. He called them "the wounded presence of God."

In this vision the Church's commitment to the work of integration, socialization, and advancement is explained, along with the spur towards scientific research.

For the disabled sufferings can have the meaning of the affirmation "I complete in my flesh what is lacking to the sufferings of Christ for the sake of his body, which is the Church" (*Col* 1:24).

For all Christians the task entrusted to us by the Risen One is valid. "The risen Lord renews his invitation (In his name... they will lay their hands on the sick, and they will be healed [*Mk* 16:17-18]) and confirms it by means of the signs which the Church performs in invoking his name. These signs especially manifest that Jesus is truly a 'saving God'" (cf. *CCC* 1507).

But we cannot remain at the level of commitment and service. The wounded presence of God in our midst cannot fail to lead to adoration, in line with the experience of E. Mounier: he called his encephalopathic daughter his "little white host."

To worship means to relativize our lives and arrive at the consideration of faith on the mystery of this presence.

The disability which weighs upon the onward rush of mankind leads to cultural searching to rediscover the true dignity of life. A vision of man is produced consonant with the authentic values of man in his correct interaction with nature and the evolutionary process of historical experience.

It is in this perspective that the disabled person eventually becomes a reference point not only for united efforts at assistance, but also as the possibility for a deeper knowledge of the mystery and a change in mentality in community life. John Paul II has gone so far as to say that the sick are our university. It is a statement which upsets the ordinary course of social life, which is based more on having than on being and does not perceive the mystery of the Christian event.

"Christ crucified is the power of God and the wisdom of God. For what is God's foolishness is wiser than men and what is God's weakness is stronger than men" (*1 Co* 1:24-25).

They do not pontificate as the masters of culture, but as ontological servants of true wisdom who by their witness point to the genuine road to conversion and salvation.

And man's salvation passes through the Cross. "Outside the Cross there is no other stairway to ascend to heaven," as St. Rose of Lima states, expressly quoted by the *CCC* (618).

In a word, their presence leads us to set our gaze on him who rose again, giving his life for others in obedience to the Father's design.

It is an invitation to change our mentality according to the Gospel precept and discover the gift of life as the element supporting all change, whether structural or dynamic, in man's experience of his personal and community dimensions.

A creative consonance between the renewal of catechesis in terms of disability and the inclusion in the *CCC* of continual

reference to the words and deeds of the saints as witnesses to the mystery of Christ should be stressed as well

The disabled now have a lively sense of communion with the Magisterium, spurred by the affectionate words of the Pope, who wants them to be close to him during liturgical celebrations

They have an instinctive understanding, though, with the saints of the past and the present The extensive citation of saints and Church Fathers reflects an urgent need that is observed: catechesis cannot be sustained only by dogmatic and moral theology Within catechesis spiritual theology is necessarily a support for the correct study of personal assimilation of the mysteries of faith, particularly by setting forth the criteria and visions of the saints' experience

The saints are witnesses and companions who cannot be left exclusively to the devotional —and sometimes utilitarian— fruition of the people.

They are examples which translate the face of Christ in every time To look to them as witnesses to faith stimulates us to see personal experience concretely according to God's design.

"We must turn to the witnesses of faith: Abraham, who believed, hoping against all hope, the Virgin Mary, who, on the road of belief, went as far as the night of faith by sharing in her Son's suffering and the night of his tomb, and many other saints" (*CCC* 165)

As regards Mary, her maternal closeness, perceived at every instant of each person's life, is seen as an interaction of experience and truth

Mary is present not only as far as Christ's tomb, but also in experience, when the breath of death is felt, and not just temporal death

From the catechesis on disability there emerges the need for reassimilating the figure and experience of Mary

Immediate consonance with the loving presence of Mary fosters access to the *CCC*'s doctrine on her life, virginity, maternity, and function in the Church

"Mary's maternity in the economy of grace unceasingly endures, from the moment of her acceptance offered in faith to the time of the annunciation, maintained unhesitatingly alongside the Cross until the crowning of all the chosen Indeed, since being assumed into heaven she has not set aside this saving mission, but with her omnipotent intercession continues to obtain for us the gifts of eternal salvation For this reason the Blessed Virgin is invoked in the Church with the titles of "Advocate," "Auxiliatrix," "Helper," and "Mediatrix" (*CCC* 969)

The dimension of prayer enters into catechesis as a basic element

Prayer is the breathing of the soul and is constantly expressed in the relationship with God

The variety in personal experience of disability, linked to the differing degrees of seriousness in handicaps, offers us portraits and contacts which are not uniform

However, disability, especially when mental, leads us towards simplification and immediacy God's goodness and Mary's beauty are constant reference points for their prayer.

Deborah, a girl with considerable mental insufficiency, sings out her relationship with Mary with the affectionate declaration "How beautiful you are!"

Mark, in a similar condition, tells Mary about his actions, what he likes, his conversations But he then waits for her response to his request: "What do you say about me?"

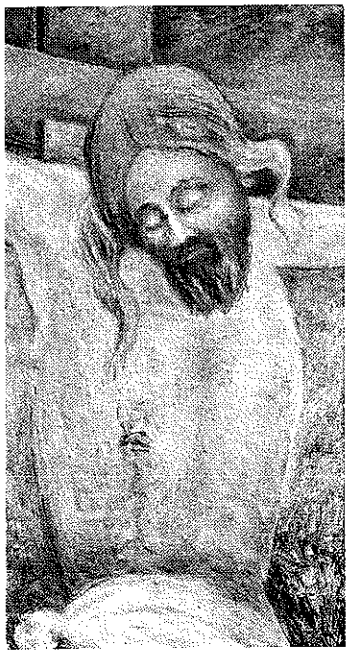
Prayer with the Bible, with the simple, inner relation of the heart indwelt by God, and with the Pope's words becomes a dialogue bearing fruit in daily life

It is communication with an echo which does not remain alien to everyday behavior

The *CCC* points to prayer experience as love and formulates the doctrinal elements enriching the relationship with God The references most consonant with the life of the disabled involve the heart and simplicity

A simple heart linking up with Jesus' prayer, arising from the invocation of the disabled, like the blind man in the Gospel: "Son of David, have mercy on me" (*Mk* 10:47).

A linkage which from disability reaches the experiences of pilgrims, monasteries, and numberless people who express the certainty of their relationship and



full confidence in Jesus: "Lord Jesus Christ, Son of God, have mercy on me, a sinner."

There is no doubt that one day, in addition to the accounts of the Russian pilgrim, the suggestive stories emerging from the journey through the world of disability can be gathered together and added to the Hesychasm series

A Methodology Invented to Involve the Whole Christian Community

The *CCC* expressly remains outside the methodological discourse. "In view of its intrinsic finality, it does not propose to implement the adaptations in exposition and catechetical methods required by the cultural, spiritual, social, and age-related differences among those to whom catechesis is addressed" (24)

But in a renewed catechesis methodology is an important datum which cannot be minimized. The following is expressly recognized.

"These indispensable adaptations are left to appropriate catechisms and even more to those instructing the faithful" (24 *passim*).

Cardinal Ratzinger has also clearly expressed this need: "Catechesis, in order to be truly suitable for everyone, must be precisely aware of the age, capacity, comprehension, life habits, and social situation of listeners. The catechist must know who needs milk and who needs solid food so as to adapt his teaching to the capacity of each." [8]

Obviously, the subject of method is broader than what may concern a technique of adaptation.

Catechetical method, moreover, is based on the basic law of fidelity to the word of God and the concrete needs of the faithful

"Fidelity to God and fidelity to man: it is not a question of two different concerns, but, rather, of a single spiritual attitude leading the Church to choose the most suitable paths for its mediation between God and men. It is the attitude of the charity of Christ, the Word of God made flesh." [9]

The methodology of the approach to the handicapped person has, in addition, explored routes until now inaccessible for the pedagogical sciences

There are, however, some possible points of convergence in the *CCC* which deserve to be stressed

a) To start with, assistance in summarizing, which always plays a significant role in learning

"At the end of each topic a series of brief texts summarize the core of the teaching in concise formulas. These condensations aim to offer suggestions for local catechesis through compact, easily-remembered formulas" (*CCC* 22)

This instruction is also valid for modern man in general, already so besieged by documents and mass media instruments, which sometimes create confusion in the end.

b) Next, throughout the text the constant reference to the Spirit predisposes us towards an attitude which is not only receptive and is, in any case, never passive in a pedagogically negative manner.

We encounter a stimulus towards participation, towards the an original realization of "doing the word," towards openness and creative availability, in the order of the Gospel's *nova et vetera*.

c) Finally, the universality of the text, within which one observes a desire for all Christians to find their doctrinal dwelling-place therein, also pertains to a universal dimension of disability.

At every racial, cultural, and religious level, disability is a fact concerning all.

In all social commitment regarding disability there is a unifying dynamic bringing people together to solve these problems.

In any case, there is reason to believe that the careful search for a way of presenting the *CCC* to the disabled will eventually have a stimulating effect on the whole Christian community. It is certain that the methodology of starting from below provokes changes and novelties on higher levels as well.

And this is what one of J. Vanier's co-workers, Henrie Nouwen, who has taught spiritual theology at Yale and Harvard and now shares his life with the mentally disabled, observes: "The members of the Ark point out new paths to me, but I have a hard time learning. It is not easy to give up old models which have shown themselves to be quite effective. But when I think of the Christian leader in the next century, I get convinced that it is precisely those from whom I would never have expected it who show me the way." [10]

Fr. RENATO GARGINI

[1] ALAN REICH, "The World's Agenda: A Half Billion Disabled People," in *Dolentium Hominum*, no. 22 (1993), p. 44.
[2] JOHN PAUL II, *ibid*, p. 8
[3] "Message to the People of God," *L Osservatore Romano*, no. 13 (Oct 30, 1987), p. 4
[4] ALVIN R. TARLOV, *Dolentium Hominum*, no. 22, p. 40
[5] *Ibid*., p. 42
[6] *Ibid*.
[7] JOHN PAUL II, *ibid*, p. 10.
[8] J. RATZINGER, *Trasmissione della fede e fonti della fede* (Italy: Piemme, 1985).
[9] *Rinnovamento della catechesi*, n. 160.
[10] H.J.M. NOUWEN, *Nel nome di Gesù* (Italy: Queriniana), p. 68

The Disabled Person and the Family

The place for the birth and subsequent development of human life is unquestionably the family, which has inescapable duties in this regard

CEFAES, the Center for Special Family Education, was thus conceived for the sole purpose of considering the family—the parentsóóas the main actors in the formative and informative action associated with the upbringing of their children—of all of them, including those suffering from a disability It provides them with counseling and support when personal emotional balance, marital relations, or family dynamics are affected, starting from awareness of the fact that the infrastructure of this upbringing is built in the family and a supportive and gratifying home that is serene and stimulating constitutes the underpinning and steadiest pillar for the effectiveness of any effort at rehabilitation. This task centers on bringing parents to deal once again with *their responsibility as the primary educators of their children*. It involves introducing into the family, by way of the couple, a suggestive and contagious process of improvement which translates, in the case of the "special child," into *full and complete acceptance of the reality of disability*, excluding possible forms of behavior deriving from inappropriate attitudes: overprotection, rejection, resignation, guilt, despair, etc.

The task of parents is to educate all their children

In this connection, the goal must be for each couple, in their own family, in their specific circumstances, with their characteristic educational style and internal dynamic, to find a suitable and well-tailored approach to the perfect integration of the child with difficulties. It does not consist of modifying educational frameworks or the advance of the home—*the challenge is to adapt, to keep in step with new needs*.

It would not be valid to facilitate mere technical information for parents—that is involved, but there is much more: to offer them the chance to face up to themselves, through active reflection permitting *a change in personal attitudes to the situation*.

For this reason CEFAES, with its open philosophy and wish to regard parents—not the psychically deficient—as the *main actors*, focuses education by starting from the Basic Pillars of Family Education, for the general principles, rooted in the person, are valid and even take on greater significance in the case of the mentally deficient, whose personal resources are diminished.[1]

CEFAES is completely dedicated to the service of families and to this end offers short courses and seminars in different cities in Spain and elsewhere on Family Education and specific understanding of children's handicaps, *for the purpose of translating theory into practice*, through the use of an active methodology with participation by students in the unfolding of courses.

The use of the CEFAES Project, "From Attitude to Conduct," a research program basically designed for these courses, gives parents the chance to *discover the repercussions of their personal attitudes on the family dynamic and the balanced development of each of their children*. People attend an advisory session where general educational criteria are adapted to the concrete problems of each family by studying the means and possibilities to make the home *a place of rest, confidence, and love in which strength is replenished to cope with the difficulties of everyday life*.

As an indispensable instrument and result of its work CEFAES employs publications, the Collection of CEFAES Notebooks, with the contributions of prestigious scientists and experts on the different facets of mental deficiency, including Professor Jérôme Lejeune These publications are short and readily understandable, since we do not feel families should become "specialists" on the different handicaps.

We shall soon put out the scientific and informative *CEFAES Journal*, with editorials, essays presenting personal opinion, current topics, a bibliographical section, news of important events, etc

The main actors for us are parents, but our work always has beneficial consequences for children. In this connection the CEFAES Video Program *Learning Through the Home* arose, for the purpose of facilitating the acquisition by the mentally deficient of habits for everyday life

The originality of the Program resides in the fact that, with the aforementioned aim, *the main actors are parents*—i.e., it is parents and siblings who teach the psychically disabled through this methodology *The mentally deficient never ought to see these videos, for the purpose of learning*

The Program consists of five areas.

1. *Personal autonomy* refers to everything people should carry out *by and for themselves*.

We are alluding to all the instruction connected with personal cleanliness and hygiene, along with care of one's appearance—e.g., showering, brushing one's teeth, combing one's hair, selecting clothes and getting dressed, eating correctly, etc

2. *Social behavior* includes all the habits and forms of conduct all people must observe in society—e.g., greeting others, using the telephone, inviting friends, etc.

3 *Granting responsibilities* involves the development of a person's capacities for a greater degree of personal autonomy and service to others. Two aspects emerge, inside and outside the home—making onès bed, setting the table, hanging clothes to dry, picking up playthings, putting away onès clothes; and going to buy bread and milk, taking money out of the bank, running errands, and getting the newspaper.

4 *Street education* includes standard behavior in getting a bus, moving about and orienting oneself in the street, knowing traffic signs, traveling, using elevators, respecting walkways, familiarity with escalators and revolving doors, and staying to the right

5. *Use of free time* refers to sports, recreation, and other useful and enjoyable activities —swimming, playing, taking walks, different forms of physical work, gardening, visiting exhibitions, table games, collecting, putting on costumes, clipping printed materials, etc

This Program *must be taught to students in and through the home*, with patience and the allocation of sufficient time, as others have done with us, without placing it on the shoulders of professionals or agencies, for *it is the family's responsibility*.

A great human quality is the capacity for initiative, a quality we parents use with all our children; but it should be even richer, if possible, with the neediest. What could my child learn now? is a question we parents must ask ourselves frequently in the family environment

In short, we are considering our child to be *one more member of the family*, with his or her peculiarities, but with a personal role within the dynamic of the home, *with the full human dignity corresponding to the person*.

Each advance, each achievement, in addition to the personal satisfaction it entails, makes the person more useful, *and, therefore happier*. Just the child? *No,* parents' joy and contentment are considerably greater.

One of our research projects involves the preparation of *religious training manuals*; it will crystallize in a volume for teachers and another for students. We offer weekly classes for different groups of the mentally deficient—adults, adolescents, and children—separated according to age and sex, in which various systems are applied to ensure their comprehension and assimilation, along with appropriate didactic material. All of this is joined to contact with parents so they will follow up at home and carry out shared, complementary work which is useful and enriching for children.

We consider it to be of prime interest to counsel groups of parents so that they will undertake initiatives on behalf of their children; to this end we prepare projects, select and train the professionals who will carry them out, review progress, and provide technical orientation. This involves offering services in which our commitment is to train and recycle professionals, supply expert overseeing, and *ensure the attainment of the objectives for which the project was created*, a project which, however, remains the initiative of the parents' group. Such initiatives may range from the organization of free time to establishing residences for adults, providing work training, or any other project a specific parents' group in a given city may wish to start up in the light of available local resources. Everything must be *in keeping with parents' freedom of choice in selecting the most appropriate situation corresponding to their educational style and outlook on life as regards the upbringing of all their children, including the mentally deficient*

The question "What will become of my child when we are no longer around?" becomes much less worrisome if *while we are at his side*, we help him to attain all the goals his capacity enables him to reach; he will no longer be a burden, but a companion, brother or sister, family member—a person who loves and is loved by his relatives and by society. Integration begins in the family and extends to other broader circles: school, work, society. And we can affirm that society accepts them.

I shall transcribe the words of José María Cuevas Salvador, President of the Spanish Confederation of Business Organizations (CEOE) and Member of the CEFAES Board of Trustees, with which he inaugurated one of our Congresses.

"At this time I believe it is important to support the CEFAES position that it is not sufficient to entrust that education to specialized centers alone, which are decisively important, but at the same time parents must also act continuously to contribute to education within the family itself.

"In this effort, to which you are all committed, CEOE offers you its support, for businessmen are sensitive to the problems directly affecting society [2]

CEFAES is a nonprofit, private organization whose Honorary President is the Queen of Spain and whose Board of Trustees includes Countess of Fenosa Carmela Arias, Mr Rafael Termes, and Mr José María Cuevas. It is supported by private agencies.

By way of conclusion, we may state that CEFAES seeks to provide a response to, and concrete means to resolve, all the questions, of whatever kind, posed by parents—by channeling energies, analyzing their attitudes and behavior, and counseling, supporting, and conducting research to achieve a better way of life in the family which favors the development of each person's personality. *All activities pass through the hands of parents, but seek to benefit the family*.

We try to make parents more aware of their duties as unique and irreplaceable educators who should not cast responsibility upon specialists and agencies for what corresponds exclusively to them; however, the road is smoothed for them to know who to turn to for orientation at every step along the way.

In the face of the birth of a child presenting psychic deficiencies, and in view of the unexpected and sudden nature of the event, symptoms of anxiety or anguish under diverse forms frequently appear in couples. This initial shock may be followed by a period of disorientation: Who should we turn to? What means are available? How should we educate him or her? These multi-

ple queries augment the initial anguish.

This situation is complicated, on the one hand, by ignorance of existing social resources in their locality and, on the other, by a lack of information on the child's psychophysical development and, consequently, his chances for adaptation to the family, school, work, and social relations in general over the course of the years

In parents and in the family as a whole, the dynamic is undoubtedly modified when a mentally deficient child is born. In everyone—more markedly in the couple and with different characteristics in the other children—there appear defense mechanisms acting unconsciously, uncontrollable and contradictory attitudes which are hard to manage and, therefore, modify Rejection and overprotection are mixed together, along with a feeling of fear of the unknown and subjective guilt which make life unbearable and embitter the home environment. If we add the factor of time to this complex description, the initial shock is tempered, things get back to normal, and *there arises a resignation marring the happiness the family may have enjoyed until then*

To achieve perfect acceptance it is necessary to cope with pain, with the suffering produced by verifying that a person we love is suffering from a disability which is not transitory, but permanent and which globally affects his or her existence, altering the individual's normal maturation and obstructing the resolution of life problems such as adaptation to the environment, learning processes, and employment

"All aspects of life are equally significant, in such fashion that suffering must be, too. Suffering is an aspect of life that cannot be eradicated, just as destiny or death cannot be put aside. Without all of them, life is not complete" (Viktor E Frankl)

We may, then, affirm that parents who accept are parents who educate, who teach children to live, who convey their sense of life, who make their children capable of fulfilling their mission —they are, in short, parents who integrate.

The other siblings also suffer a shock over the birth of mentally retarded person, and the parents' mission is to clarify, explain, palliate, and help each child according to age, situation, and capacity.

The psychically disabled are born within families, and none of the members can stand aloof from this event Parents' prudence and common sense will determine in each situation what they ought to be told and when. In any case, it is not desirable to deceive them, but they should be helped to accept the retarded and not be ashamed of them in relations with their friends. The best advice is to deal with this naturally, and right from the start—forgetting one's one pain—see to it that each member of the family is playing his respective role

It is important to situate the mentally retarded in the place corresponding to them within the family and to ensure that the others respect and love them, avoiding overprotection, which impoverishes the person, and creating a climate of joyful, balanced naturalness

Parents should consider that siblings educate each other and

that this dynamic is fostered if they offer an example It would not be beneficial for the retarded child to be treated as the "eternal baby" and not be taught the family's habitual norms of conduct, for we would then be "disintegrating" the child or obstructing school, work, and social adaptation.

In addition, it may be the siblings who will assume responsibility for the retarded in the future, and it is a task for the whole family to ensure that they will not become a burden, but be instructed on all the abilities which the rest of us have learned within the home.

One risk faced by parents with a mentally retarded child is to burden their other children with responsibilities not corresponding to them, for which they are usually unprepared and which make them see their retarded brother or sister in a negative light. If to this conduct by parents there is added overprotection by one or both of them in providing excessive care, the other children may interpret it as a lack of affection towards them and a feeling of envy may turn into hatred of the person occupying all the couple's attention. This process may sometimes fall upon just one of the spouses, the mother, while the other tries to balance the situation by playing the opposite role

Finally, *we must consider the magnificent cooperation by siblings in the social integration of the retarded* if they take them into account in making plans, invite them out with their friends, and include them in their games and outings insofar as possible while accepting their limitations. Siblings can play a decisive role if they make the retarded a part of their own social life This does not mean that the retarded can and should do everything they do, but that they must try to teach them sports and games and not flee their company in ordinary life.

This will probably be facilitated if parents have created a natural climate in family living and themselves put into practice the notion of the retarded child as just one more member of the family and act in accordance with that truth

We understand parents' concern, which is licit and real; for that reason we feel they need support which will clarify, advise, inform, and provide initiatives—*for their way of life at home is chosen by them*—so that they can fulfill their main desire: to their children happy, all of them, including the retarded *To do so, our responsibility as professionals is evident in terms of offering parents technical data from a genetic, neurological, biochemical, psychological, pedagogical, and religious standpoint which will enable them to make decisions by reducing the margin of error*.

In addition, we must appeal to the good sense of parents so that they will inform themselves with sufficient data, in contact with efficient, reliable professionals, so as to *form a proper judgment before making decisions which will influence their child's future*.

Parents must unite and make an effort to obtain what is best for their children, and, without a doubt, *what is best is the parents themselves when they act consistently*, certain that this task must be begun sooner or later, but convinced that it is always time to begin

MARÍA TERESA VÁZQUEZ
Vice President of CEFAES

[1] Teresa Vázquez Alumbreros, "No te rindas ante la deficiencia mental," in *El deficiente mental en la familia* (Madrid: Rialp, 1988).

[2] National Meeting for Parents of the Mentally Retarded on "Objective Reasons for Hope," Opening Address by José María Cuevas Salvador (Madrid: Colección Cuadernos CEFAES, 1988)

Patient-Centered Nursing

1. Introduction

Patient care, if we use a Kantian philosophical focus, involves three distinct perspectives which at the same time constitute a single reality. In terms of differentiation/uniformity we shall employ the Kantian doctrines of

a) criticism of pure reason,
b) criticism of practical reason, and
c) criticism of judgment.

This is our first form of questioning: to have available ideas, a correct philosophy oriented towards knowing the hows, the whys, what our prime motivation in care is. We place ideas at the forefront of patient care.

Consequently, through philosophy, with motivating ideas, we propose our second form of questioning: to know the techniques, methods, and protocols of care. Without close technical contact with patients, without essential resources to relieve, encourage, revive, help, calm, console, and cure, our care would prove a pipe dream rather than a reality.

Thirdly and finally, we apply knowledge on judgment and aesthetics as a sure path to obtain a correct ethic of care. Aesthetics presupposes or requires quality and analysis, verification. Nursing must equip itself with knowledge, aptitudes, and attitudes.

2. Holistic, Humane, Patient-Oriented Treatment

2.1 *Initial Approach to the Patient*

We are accustomed to differentiating or clarifying to some extent the fields of medicine and nursing. We thus specify that medicine is particularly concerned with fulfilling the following functions, activities, and tasks: diagnosis, prognosis, and prescription of treatment—i.e., curing.

Nursing focuses its functions, activities and tasks upon meeting the sick person's basic needs, rehabilitating, applying treatment and observing results, i.e., providing care.

The preceding is summed up in Figure 1.

Certainly, the question posed is not always so Cartesian, but it may well be offered as a good approach to correct patient care. And the content conveyed here is not entirely correct, for holistic, humane patient care is much more complex, rich, and gratifying. This treatment requires many other health professionals, as we shall see throughout this paper. We shall therefore stick for the moment to the concept of basic attention to the human person. In addition, we shall deal with the subject more in terms of the nursing profession.

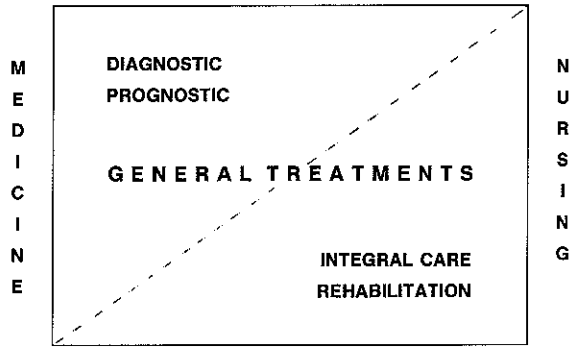


Fig. 1

2.2 *Health and Illness*

When we speak in nursing of the patient's needs and of basic care, I feel there is conventionalism, mimicry, and obsolete thinking. As nursing professionals we should reformulate these time-worn phrases and start dealing with and talking about the health needs of people, in the threefold anthropological dimension of the person as individualized, immersed in a group, and belonging to a certain community.

Furthermore, before dealing with the above-mentioned aspects of those who are sick and in need and require our attention, we should consider the following forms of behavior on our part: our objective, thorough preparation; the most adequate methods and programs available to us; economic resources as an aid to programs; the environment and its human and technical resources; what we mean by health, illness, and prevention; the geographical distribution and needs of individuals; the priorities among different needs; designing work to reach a goal; and formulating research as a means to constant progress.

We must avoid falling into the temptation to establish a list or litany of needs, a sort of summary in which the health needs of each person are condensed. We believe there must be more study and better analysis, and in-depth research into what man is and how he behaves before the imminent risk of losing his health or during his illness. Under the circumstances of a life crisis, people never respond in the same manner. Everyone is different and maintains his personality; all individuals are unique. There is unity in a personality, although an existential dichotomy is inherent in it, i.e., a constitutional temperament that is to some degree unmodifiable and a character shaped by daily experience from childhood until the end of life.

As for the concept of health, we regard it as a balance be-

tween the individual and the environment surrounding him —taking the environment, of course, in the a very broad sense: space, culture, beliefs, politics, socioeconomic status, friendships, work relations, and so on.

WHO, in the definition of health it formulated on April 7, 1948 for its Constitution (Article 25) states that:

— the aspiration of all peoples is the maximum enjoyment of health for all citizens;

— health is the state of complete physical, mental, and social well-being, with no discrimination based on religion, political creed, or social class;

— every man has the right to preserve his health and, in the event he becomes ill, to possess the means to obtain a cure;

— this protection must encompass not only him, but the members of his family.

More recently, the Ambit d'Estructura Sanitaria del Congrés de Cultura Catalana stated (November 1976) that health is that way of life which proves most "autonomous, solidary, and joyful."

If, after analyzing the concept of health, we pass on to consider what illness is, we come across more difficulties. We may say that illness is the other side of health, a certain disorder altering the equilibrium of well-being. Illness is the appearance of a crisis in our state of health, a crisis which alters our security and our freedom and makes us more dependent, with the appearance of new needs. If we wished to depict this process, we could represent it graphically as in Figure 2.

Here "1" represents the state of health and security, and "2," the alteration of the life balance, or crisis; "3" stands for the recovery of the physical and psychological state of security and freedom, and "4," the new, negative state of illness, dependence, the need for more attention, a lack of security and freedom, and perhaps death.

In terms of our health-related framework, we may say people's needs continue to increase as they move from primary preventive care to a secondary and eventually tertiary phase.

2.3. *Illness as an Agent of Change*

In continuing with our discussion of peoples needs we immediately observe that in every individual the fact of becoming ill produces a change in personality structure. Ego, super-ego, id, and self undergo profound alteration. This change is normally manifested by a series of reactions which, when analyzed and grouped together, constitute the generalized expression of a state of mind:

— depression, with the fragmentation of security;

— regression to primary stages, as in the Freudian theories;

— anguish, with doubts in the face of the unknown and fear;

— aggression, with discontented, demanding, critical, and acquisitive attitudes;

— resistance to change and nonacceptance of being ill.

The preceding points, which we shall not analyze in detail at this juncture, involve an incursion into the unknown, into what is new, changing, and negative; this is the passage from the state of health to illness. This passage, in agreement with L. and R. Grinberg, "constitutes a real revolutionary change, for the individual must undergo a painful experience of periods of disorganization of psychic systems, established structures, and bonds to objects in order to integrate himself into a reorganization leading him to shape a new identity."

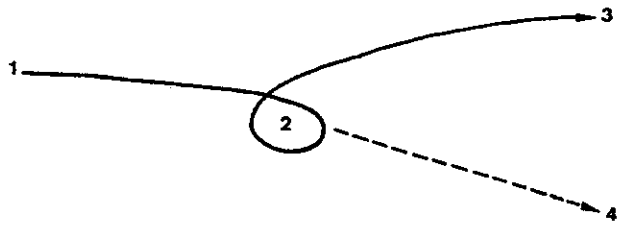


Fig. 2

3. What Patient Care Should Be Like

From the standpoint of nursing we have reached the conclusion, supported by our daily work with patients, that care should include the following elements:

a) first of all, to study the patient's self;

b) to analyze and attend to somatic needs;

c) to respond to social needs;

d) to consider psychological needs, and

e) to respect anthropological-cultural needs.

3.1. *The Patient's Self*

In this presentation we shall adopt the psychoanalytical theories and concepts of the self of our patients or clients as developed by H. Hartmann (1950) and P. Heimann (1951) and clarified more recently by L. and R. Grinberg.

For the Grinbergs, it "includes the self and the nonself. It is the totality of the person itself. It also includes the body with all its parts, the psychic structure with all its parts, the bond to external and internal objects and to the subject as opposed to the world of objects." "The nonself," for these authors, "comprehends external objects and the external world." While bearing in mind the preceding definitions and the fact that every alteration in health in any individual produces a change, an alteration in personality, an imbalance in his sense of identity, as we previously observed, we shall psychoanalytically formulate the situation of the patient lacking health who comes to receive our help. For, by knowing the client's new, individualized structure, we can approach him better and offer him more adequate service, greater satisfaction of basic needs. Let us not fall into the absurdity of paying attention to a small segment of the subject without analyzing and studying in depth, without seeing the whole through each of the parts. Let us not just gaze at the iceberg—recalling Last—or judge it by what we see. Let us investigate and individualize each iceberg and the capacity and volume of each. Every iceberg is

different All icebergs are much bigger than they appear to be. No person is the same as others Each has his own individuality, his differentiating peculiarities

3 2 *To Analyze and Attend to Somatic Needs*

The notion of the body, as L and R Grinberg state, proves essential to the consolidation of the individual's identity We, as nursing professionals, must gain deep knowledge of the body—its physiobiological reactions and needs, its different chronological stages, and its peculiar ways of acting and undergoing alterations of its normal course, etc. We must thus pay attention to the indispensable basic needs:

— of the child before and during birth;
— of the premature or terminal child;
— of the nursing child, healthy or ill;
— of the child in first or second infancy;
— of the adolescent, with his different ways of reacting;
— of young people, adults, the elderly, and the decrepit;
— of the fundamental, differing, and differentiating needs of men and women, their physiological or somatobiological characteristics, and their biosexual, hormonal, genetic, reproductive, and other processes and needs

In this section we must consider current knowledge of the corporeal framework

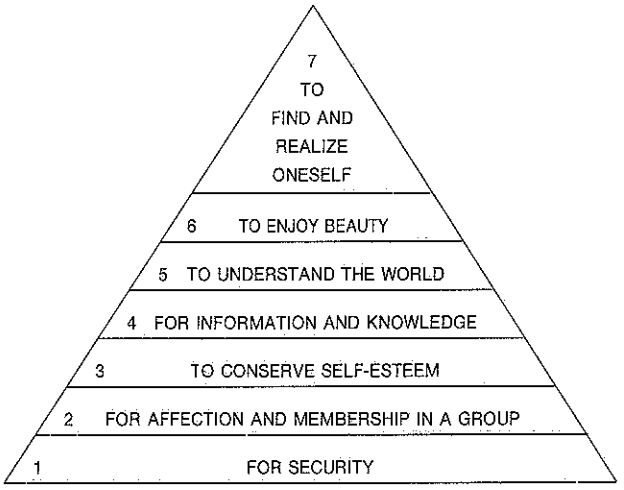


Fig 3 - **Needs**

3.3 *Attending to Social Needs*

Healthy people have sociological needs throughout their lives If they undergo the misfortune of losing their health and fall into the state of illness, their needs increase. These needs are often specific to a certain age in the concrete process of their illness. The sick person needs to continue with his schooling, work, social, family, and community life, housing, hygiene and health care, mobility, etc

The sharp change sometimes involved with illness places an individual's personality in difficult sociological circumstances Sick people may move from a state of integration into a group as members or leaders to one of isolation from the family, professional, social, political, union, or other circle

Here as well, the definitive social change of a human being is death. The dying, at the decisive stage of the life, crisis, may be intensely assisted by the social environment or, on the contrary, abandoned by all closest to them They may spend their final moments at home or be subjected to a mechanical, dehumanized, and dehumanizing control, depending only on a little red light flashing on or going out at the decisive moment of death.

3 4. *Considering Psychological Needs*

Professor Pinillos, one of those who taught me Psychology, states, "Working out a repertoire of acquired motifs constitutes an enterprise of doubtful significance Murray, for instance, in his *Exploration of the Personality* (1938), specified a list of needs he termed 'psychogenic,' to distinguish them from viscerogenic needs, where he identified six groups, with four or five needs within each group, up to a total of twenty-eight. We shall not overburden this point with annoying enumerations, but we shall mention the fact that in the glossary of his book Murray cites as many as eighty-four different needs."

The needs of the person which we shall apply to every individual deficient in health are simplified to some extent by Maslow, who reduces them to seven (see Figure 3).

At present a lot of attention is being devoted to so-called "neurotic" needs, which we may summarize as the need:

a) for affection and approval;
b) for company;

c) for power over oneself and others;
d) to exploit others, and
e) for recognition.

Broadly speaking, these needs involve the difficulty of transforming the client into a narcissist, with a vision of life devoid of the value of reciprocity

3.5. *Respecting Anthropological-Cultural Needs*

The field of anthropology is broad, and we must be familiar with it. Anthropology is a branch of knowledge which affects the nursing profession because it deals with the human being, speaks about the human being, and is a science of the human being. We should ask ourselves about the topic of "anthropologically-oriented nursing." And it would lead us to know the laws, rights, obligations, and organization of healthcare and professional institutions.

Cultural anthropology introduces us into the field of respect for customs, the family, and ethical identity, which, according to E. Fromm, "discusses and defends the problem of ethics, of the norms and values leading man to realize himself and his potential."

Within cultural anthropology we also consider the religious factor as a system of beliefs, an anthropological-cultural reality, and a profound sensibility of mankind which we must respect.

For Sir Edward Burnett Taylor, the father of anthropology, as cited by Harris, culture is "that complex whole comprehending knowledge, beliefs, art, morals, law, customs, and any other capacity or habit acquired by man as a member of society."

We agree with J. San Martín that "the meaning of the philosophy of man, philosophical anthropology, involves a theoretical, practical, and epistemological discipline." I would also term it a discipline of cultural hermeneutics seeking a universal discourse: communication, questioning, and comprehension of the human being, openness to others, and a helping relationship.

We have graphically summarized our thought on what patient care should be like (Figure 4)

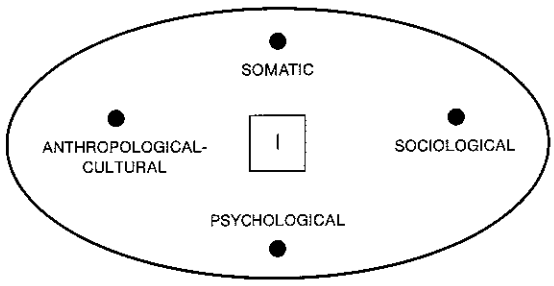


Fig. 4

4. Conclusions

The preceding points have set forth what we understand and try to practice in the nursing profession. This is our way of perceiving and achieving holistic and humane nursing. We accept and respect it as such. Patients, healthy or sick people, request this with their eyes, hands, gestures, or words.

We shall conclude this article by insisting strongly upon the importance of the integral study of man, knowledge of his personality, somato-socio-psycho-anthropological and cultural analysis of the self of each of our clients, for the sole purpose of knowing them well, treating them correctly, and identifying them in their complete individuality. Let us not deal with them partially. When a client comes to us, we are faced with a person in need, not a walking illness.

The truth is that such meticulous attention to the person lacking health requires reflection, study, criteria, philosophical principles, and a deep sense of professional responsibility. Care is a reality which is not harmed by a bit of utopianism —i.e., a touch of idealism, naivete, vision, insight, or the desire for something good or better.

Finally, we feel that when we attend to patients only under a physical aspect, forgetting or neglecting the remaining elements of the self, we offer these people care for just a fourth of their real needs.

Rev. C. ESEVERRI CHAVERRI

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Testimony

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Chile: Hospital Care and Medicine in a Catholic Spirit

ANFASS and the Family in Society

Venezuela: Annual Plan for Professional Training

Colón: General Report on Pastoral Care in Health

Spanish Bishops' Conference

Programming of the Pastoral Care in Health Department for the 1993-1996 Period

Objective 1

To contribute to promoting a new culture in the world of health by viewing the facts, problems, and situations arising there in the light of the Gospel

Action

1. To hold the National Conference on "Church and Health" to stimulate and facilitate active participation by all the Dioceses, sectors, and pastoral workers in healthcare. The projected dates are September 26-30, 1994

2. To devote the Day of the Sick in 1995 and the corresponding campaign to directing the light of the Gospel towards the meaning of human suffering and attention to it.

3. To speak out on situations in the health field which involve conflict

Objective 2

To renew the celebration of the Sacraments of the sick

Action

1. To devote the 1994 *Day of the Sick* to the topic of celebrating the Sacraments during illness, with the following aims:

a) to examine the administration of the Sacraments during illness from a pastoral standpoint;

b) to rediscover the therapeutic dimension of all the Sacraments, particularly those celebrated during illness;

c) to renew sacramental practice.

Objective 3

To intensify the Church's and society's solidarity with the most neglected of the sick, especially psychiatric patients and the elderly

Action

1. To take advantage of the National Conference on "Church and Health" to study the serious problems faced today by psychiatric patients and their families and the Church's lines of action in this field.

2. To devote the 1996 Day of the Sick to create awareness in the Church and society of the situation of psychiatric patients and their needs and to promote evangelizing action in this area of care.

3. To foster and support the creation of associations for the families of psychiatric patients

4. To devote the 1997 Day of the Sick to create awareness in the Church and society of the elderly who are ill and their needs and to promote evangelizing action in this field.

Objective 4

To identify the spiritual needs of the terminally ill and promote attention to them as an integral part of palliative care.

Action

1. To study the spiritual needs of the terminally ill, their families, and the professionals assisting them

2. To reflect on the specific contribution of spiritual attention to overall care and make it known.

3. To spur the pastoral training of chaplains, pastors, health professionals, and volunteers to provide spiritual care to the terminally ill.

4. To include spiritual needs and attention to them in the training programs for professionals assisting the terminally ill and in commissions pertaining to palliative care associations

5. To reflect on the ethical questions arising in care of the terminally ill

Objective 5

To revitalize Catholic pastoral care services at hospitals and their proper functioning in accordance with the needs of our time

Action

1. To assist the people engaged in Catholic pastoral care services from a human, spiritual, and pastoral standpoint

2. To press for and facilitate the initial formation of new chaplains and competent personnel and refresher courses for everyone

3. To augment in Catholic pastoral care services the programming of work, carried out and evaluated by a team, and its integration into and coordination with other hospital services.

4. To clarify the figure of *competent persons* and offer practical orientations on introducing and integrating them into services.

5. To conduct a thorough study of the current situation of personnel in Catholic pastoral care services and needs in the near future.

Objective 6

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

Action

1. To see to it that all the Interdiocesan Secretariats for Pastoral Care in Health are represented on the National Commission and provide real pastoral leadership in dioceses.

2. To ensure that on the Pastoral Care in Health Delega-

tions in all dioceses there is someone who assumes responsibility for promoting and coordinating this ministry in parishes.

3. To promote knowledge of health problems and participation in solving them in parishes.

4. To strengthen overall care of the most neglected sick in parishes, especially psychiatric patients and the elderly

5. To gather together and disseminate the abundant material existing on pastoral care in health in the parish and facilitate its use.

Objective 7

To train Christian health professionals who are committed in this field

Action

1. To organize yearly Christian Health Professional Symposia as a place for encounters, reflection, and commitment

2. To offer Christian Health Professionals in the dioceses material for training in bioethics and pastoral care

3 To start up an Association of Christian Health Professionals as a public organization of the Church.

Objective 8

To support and strengthen current channels and instruments for training in the healthcare ministry

Action

1 To hold a yearly meeting of directors or officials of Schools for Pastoral Care in Health The last one was held on October 30, 1993.

2 To organize one or two courses a year for ongoing training of pastoral workers in health care. The topic of "The Eucharist at the Hospital" was recently studied, October 25-29, 1993

3. To propose to the Commission on Seminaries and Universities that pastoral care in health be included in the training of seminarians and provide it with orientations, programs, and documentation.

4. To organize a service for exchanging educational material on pastoral care in health among schools, dioceses, and other entities, along with information on materials and instruments for training pastoral workers in health care

5. To study the creation of a Pastoral Care in Health School for the whole of Spain

6 To promote sending pastoral workers in healthcare to study at the Camillianum in Rome.

Objective 9

To use the mass media more and better to disseminate the healthcare ministry

Action

To consult media experts on how to augment and improve use of this resource

Objective 10

To foster closer ties and cooperation with civil and Church organisms involved with health care.

Action

1. To communicate our activities and projects to civil organisms in health, particularly the World Day of the Sick and the National Conference on the Church and Health.

2. To maintain ties for information, exchange, and cooperation with other organisms of the Spanish Bishops' Conference, the Pontifical Council for Pastoral Assistance to Health Care Workers, the organisms for the healthcare ministry of the Bishops' Conferences of Portugal, France, Italy, Belgium, Latin America, etc., and with the international federations of Catholics in the health professions (e.g., FIAMC, CICIAMS)

Objective 11

To support and assist the Diocesan Delegations for Pastoral Care in Health in carrying out their mission and functions.

Action

1 To send Delegates periodical circular letters with information which will contribute to communication, exchange, and enrichment for all and to request, to this end, that they inform our Department on their activities

2. To hold a yearly National Meeting of Delegates for Pastoral Care in Health as a place for encounters, reflection, and commitment

3 To develop the action foreseen by the Mutual Assistance Plan of the Diocesan Delegations for Pastoral Care in Health

4 To consult those involved about holding a short theoretical-practical course for Diocesan Delegates who are just beginning in this function.

Chile: Hospital Care and Medicine in a Catholic Spirit

It is hard to deal with such a complex and extensive subject in a few words. The essence of Catholic medical attention is contained in the parable of the Good Samaritan: charity towards those who suffer, regardless of their social condition, race, or religious creed

Medicine has been assigned the task of protecting life (fundamentally, protecting *endangered* human life). The obligation of medicine includes the weak, the defenseless, and the sick. The physician's duty is to place himself at the service of man from the beginning of human life until its biological end.

There are several institutions in our country which are facing the challenge of providing medical care in the spirit of Catholic doctrine

St. Bernard's Parish Hospital is one of these institutions It has taken on this task, seeking to place itself at the disposal of the human person, from the first instant of life until the moment of death. At present anti-birth policies, artificial fertilization programs, and medical interventions affecting the lives of thousands of individuals are leading to situations which violate people's dignity. In open defense of life, at the Parish Hospital we have implemented a Responsible Parenthood Program based on respect for natural biological rhythms in which engaged people and married couples are instructed on techniques for self-diagnosing fertility

The program supports the Family Ministry of the Diocese of St. Bernard in the catechesis of those to be married, and team members contribute their scientific knowledge for one of the courses in the curriculum of the St. Bernard Diocesan Seminary.

Our patients, as well as the physicians working at St. Bernard's, know that at the Parish Hospital sterilization is not practiced, contraceptives are not prescribed, and intrauterine devices are not implanted

In addition, for several years the Hospital has been actively cooperating with a program to prevent abortion and rescue both adult women and teenagers who seek to abort.

The world is scandalized by illness and hopes medicine will eliminate it from our existence.

The sick person insistently recalls that our earthly life is finite and fragile. Fear, insecurity, and little tolerance for the idea of death lead some people to distance themselves and, in extreme cases, abandon their seriously ill relatives Furthermore, the hospital system tends to exclude fa-

mily members, leaving the care of the sick exclusively in the hands of professionals. Patients die surrounded by high technology and minimal humanity. At the Hospital we stimulate and facilitate visits by relatives. The children of hospitalized children are allowed to stay with them for most of the day. They are made to feel like an integral part of treatment. When they are present, they feed their children, change them, hold them in their arms, and accompany them to laboratory exams and X-rays.

Adult hospital services allow visits every day. We motivate family members to collaborate with the activities of patient care which they can carry out, such as feeding the elderly, changing bed linen, and so on.

These activities are based on professional criteria, but also on the task of Catholic medicine in helping relatives to care for their sick in a worthy manner.

The hospital assistance we seek to provide takes into account the fact that the human person has been created by God according to his own image and achieves fulfillment in this life as a unit consisting of body and soul.

This creature loved by God for itself, transcendent, and called to eternal glory has a dignity which must never be disdained, but, rather, respected and protected. Man is a substantial unity (an incarnate soul and an animated body) and illness is thus experienced not only in man's physical substrate, but in his totality.

It is not infrequent to observe that the illness manifesting itself in the body has its origin and true cause in the hidden depths of the psyche or human soul.

The presence of women religious and priests in our hospital wards is a source of spiritual support. We are interested in accentuating and augmenting that presence.

The priest shortage in the Diocese has not allowed us to have a permanent Chaplain available. We feel that with the support of the Diocesan Seminary we can now implement a pastoral plan aimed at both staff members and patients.

No social or technological change ought to divert our attention from the patient, whom we are to look after as a creature of God and brother or sister of Christ. Our condition as baptized people makes us recognize others as brothers and, just as in the natural family, the patient is a special brother calling for our concern and compassion in an exceptional way.

A compassionate doctor feels and suffers alongside the patient, understands the suffering experienced by the other person, wants to help him, and sacrifices himself for him. He helps patients even when inconvenience or risk is entailed.

This is urgent today, when self-interest takes precedence over all other considerations. It is possible to feel compassion for the patient while acting with the diligence, promptness, and affection that patience requires.

The primacy of self-interest is seen under many aspects:

— in health personnel refusing to attend to AIDS patients out of fear of infection;

— in doctors who behave like medical entrepreneurs;

— in those who work only where they are paid more.

Christian compassion humbly respects the autonomy of the sick. We violate patients' humanity when, even in the name of benevolence, we trample upon their decisions.

Until some time ago health was seen as a gift (the old medical saying, "I bandaged you, but God cured you," reflected that belief). At present health is regarded as a right. I suppose this mirrors a secularized view of humanity and society wherein there is felt to be an interplay among the forces of the individual, the family, the community, and professional groups. Man's relationship with his Creator is not considered, at least not explicitly.

It is clear that health is not the supreme good, for either the professional or the patient. Health is a necessary condition to enjoy the person's capacities and struggle to be happy. In other words, health is a quality of life; "it is the physiopsychological condition in which a human being's life can develop normally." It is a good, in this sense, hierarchically inferior to life itself. The doctor's motivation assumes this basic premise. The search for health forms part of the set of goods the person pursues, and its priority is, therefore, determined by persons themselves.

Compassionate medicine involves attentively caring for the patient whom cannot be cured by medical science: the chronically ill, the mentally weak, and the dying.

St. Bernard is a poor municipality. In our emergency service it is not infrequent for us to treat patients brought in by neighbors or the police who suffer from incurable illnesses. Our experience indicates that such patients have tramped from one health service to another asking for help and have been systematically rejected. For these people, sick and poor, we maintain, in conjunction with The Home of Christ, a special ward to receive warmly the most dispossessed in our society.

In this ward for palliative care attention is given to terminal patients so that they can live through the final stage in their existence in a dignified way. Most of them have been abandoned by their relatives, and the staff of this ward makes a significant effort to establish contact with them. They have often been successful, and after the work of education relatives have received the sick again in their homes.

We can joyfully state that in this ward adults have received Baptism, Confirmation, and their First Communion, and all who have died have opportunely received the Anointing of the Sick.

Finally, as Catholic physicians we must give new meaning to the doctor-patient relationship and rediscover the Christian meaning of suffering. The progress of science and technology is aimed at overcoming pain and death. The illusion existed of being able to achieve victory. Pain and death are more threatening today. Christianity reveals the possibility of reconciling a necessary struggle to overcome suffering with the chance to take advantage of its constructive and redeeming value. That is why the Holy Father for himself asked those suffering for "the support which can come

from the gift of suffering accepted as an instrument of redemption and life" The Holy Father calls everyone who suffers to give constructive meaning to personal pain.

All Catholic health professionals, especially those of us working inside hospitals, are called to adopt these words of the Pope inviting the sick to be generous in offering their pain We, too, receive from the Church the invitation to consider our professional work, when well done, as a concrete road of personal sanctification.

Rev. BALDO SANTI, O M D.
Executive Vice President, Chilean Caritas

The Italian Association of Families with Retarded Children and Adults

The National Association of Families with Retarded Children and Adults (ANFFAS) was formed in Italy in 1958 and officially recognized in 1964 (DPR no. 1542).

It works all over the country for the well-being and protection of mentally handicapped people and their families, promotes recognition of the rights of citizens with this particular disability, and organizes numerous services for assistance and rehabilitation.

Today, more than thirty years after its foundation, ANFFAS has over 15,000 active members divided into 192 branches, a fact which demonstrates the validity and necessity of the original idea The Association has at its side many friends who collaborate in various ways, from economic assistance to the concrete work of volunteers, and is active throughout the nation in prevention of and provision of care for psychological handicaps. It is ever present in those areas where the notable and pressing problems of such persons are experienced and discussed. It stimulates and promotes effective action by public and private agencies and constantly takes part in local, national, and international conferences.

In recent times the role of the family as the basic cell of society has further affirmed itself, an essential point, too, for the search for political solutions in a continuously evolving context; in these situations, family movements are one of the most natural expressions of citizens working in social activities

Recognized as an association in the public interest and a leader in promoting social concern and action, it forms and informs on family life, brings out the value of the roles of motherhood and fatherhood, points to lifestyles based on stability in difficult situations, suggests the path towards proper educational responsibility, and locally manages services in a society that is too indifferent to these problems; in addition, it frequently stimulates a political response, in a decisive field for cultural life as well.

Society too often forgets that alongside every disabled person there is a family undergoing continual periods of emotional stress without respite, a family struggling to acceptóóin an era in which the irrational seems to have been banned by a technological cultureóóthe unforeseen birth of a handicapped child, which almost always induces a state of crisis therein, in terms of both organization and identity.

In any case the birth of a child requires organization which is not always easy, even mentally, of the functioning of the family context, all the more so when a child "different" from the one expected is involved According to the type of information the family receives on handicap, a process of casting blame is provoked which often involves all the members, and not just emotionally.

The stress of families with problems depends not only on the objective seriousness of the children's state, but also on the way the event is interpreted and assimilated. Fundamental elements at that stage are knowledge and information on the handicap, the resources present in the family context, and extrafamilial support, these are indispensable to acquiring the capacity to establish a hard-won dignity in the social and family environment without letting oneself be overwhelmed.

In the last Italian legislative term there were over seventy proposals and bills related to the "family," proof of the fact that these problems are basic to the

creation of new families, to their growth in autonomy and expertise, and to support for them in difficult situations Part of this period is the announcement, in the most advanced European countries as well, that the family, as the underpinning of society, must be the object of further study and careful analysis.

The UN, too, through the Declaration on Disabled Persons (Dec. 9, 1975), states (Articles 12 and 13): " The families of disabled persons must be exhaustively informed with all suitable means on the rights contained in the Declaration itself and appropriately consulted on everything regarding the rights of disabled persons."

ANFFAS belongs to the Italian Union of Family Organizations, one of the few bodies in which the private sector plays a basic role, and the services offered are not merely of a social security type.

Among the most serious problems to be faced by the members of ANFFAS is the question "What will happen when we are no longer around?", often posed by parents with tears in their eyes; not even the recent Italian general law on the disabled managed to, I won't say "resolve", deal with it at all This problem, because of both the advanced age of ANFFAS parents and, too often, the seriousness of the handicap itself, is hard to solve.

Seriously disabled adults are almost always completely dependent on their families, generally on mothers, above all; therefore, housework and the labor of those remaining at home for this reason should be valued to the utmost, and a privileged economic status ought to be established.

The general law on handicaps grants some assistance to family members who work, but it is really very little in comparison to the actual needs of the relative of a psychically handicapped person.

Nowadays the families of seriously disabled adults turn increasingly to volunteer organizations which, like ANFFAS, respond with an attitude of respect for the disabled

Parents who are ANFFAS members working as volunteers act jointly with other similar associations to contact the appropriate organisms, stimulate the formulation and modification of laws, and protect the civil rights of the disabled

And this is also one of the aims of the Association's publication, reflecting the conviction that the more information there is, the more the problem will be examined and understood.

It is often forgotten that the family is one of the essential agents in society The mass media are slow to take it into account and devote space to it only to cast blame when family-related events become front-page news. It is forgotten that it is up to the family to cope on a day-to-day basis with the inadequacy of social services and bear the weight of those who are not self-sufficient.

WHO estimates that 75% of all health care is provided in the informal context of the extended family, and it is here that illness and disability are dealt with and treated

The Italian agency for statistics, CENSIS, in a recent study recalled that in 1990 15% of the nation's families were involved with assistance and care in the home of a sick or disabled person; in 77 5% of the cases they bore the full burden of care. This proves that all other policies, economic, social, or related to construction, education, work, and welfare, must be gauged in terms of the family

The family is, furthermore, the first to fulfill the irreplaceable role of building those meaningful bonds that give direction and hope to the life of each child, particularly if handicapped.

In recent decades it has been shown that a person's chances for cognitive and emotional development, especially if disabled, increase with the acquisition of new knowledge and functional abilities, when these are encountered in a stimulating social milieu rich in initiatives and experiences and shared with normally endowed persons

It is precisely in the family that the disabled find the reassuring responses enabling them to grow emotionally and intellectually and satisfy the need for relationship which develops their identity.

Wherever the family is made to bear the full social weight of the most burdensome situations, without being aided and prepared, there are in fact unpleasant side effects for all the members of the family itself, they are often isolated from social relations, with a real risk of regressive reactions

ANFFAS is present in this sphere as well, in education, with action to stimulate and support scholastic integration, and in professional training, with the conviction that work is therapeutic and the path enabling the disabled to play a role in society

334 conscientious objectors are now performing civil service at our branches—mostly personnel qualified to assist our young people; after their term of service they remain as "friends" of our centers In this respect, too, ANFFAS does volunteer work in training the young, who, with their expertise promote and perfect services and reduce the risk of bureaucracy, representing a stimulus through ethical motivations and their manifest enthusiasm in this work

Volunteers, then, should be accepted not just as a source of service, but as a force for change; they should be prepared and encouraged by way of specific training programs capable of embracing community commitment in terms of the real needs of the disabled

In this perspective, the training of volunteers (as well as conscientious objectors and all those working in collaboration with ANFFAS) helps people to emerge from difficult situations, also shaping a political dimension to the relationship of solidarity and problem-sharing.

ANFFAS, then, places itself alongside families in difficulty, identifies services, uses the resources of volunteers, locates specialized personnel, helps people not to neglect their other children, and seeks to keep the marriage relationship stable Nationwide, it stands as an essential bond for the advancement of both psychically handicapped people and their families.

RENZO TORNATORE
National Chairman of ANFFAS

Venezuela: Annual Plan for Training Professionals to Treat Children with Neurological Problems

Introduction

In Venezuela there are many thousands of children with some kind of brain damage and the resulting social problems connected with neurological disorders. It is a well-known fact that, in spite of both governmental and private efforts, only a small percentage of existing cases are attended to. The ensuing deficit represents a personal drama for thousands of poor families and a major social problem as these children grow up. A permanent concern for rehabilitation specialists has been the difficulty of reaching the patients residing in rural areas, far from the corresponding medical facilities, or in outlying districts presenting great difficulties for transportation.

These problems have been broadly dealt with by organisms such as the Faculty of Medicine of the Central University of Venezuela, the Venezuelan Association of Physical and Occupational Therapists, and the Health Ministry, with a view towards finding a solution.

Aware of this need and of the importance of stressing and restoring the sense of the dignity of each Venezuelan, Provive two years ago started up a pilot program with twenty-five families. It has been a considerable success, with such positive results that we now have a waiting list of two hundred families.

In this connection, Dr Solís, Director of the International Institute for Holistic Brain Development, headquartered in Ashland, Oregon, comes to Caracas twice a year to evaluate children with neurological problems preselected by a group of Provive specialists (educational psychologists, physicians, and social workers) and then designs the integral rehabilitation program which the parents and relatives of each child must learn in order to apply it in their respective homes.

The instruction of parents offers the following advantages, among others

— It obviates the difficulty or impossibility of transporting children on a daily basis to a care center where, after a long waiting period, they can be attended to and enabled to do exercises for a very short time, since they must share resources with other patients

— Transportation is particularly difficult for those patients with some form of disability; ordinary public transportation must be used and may prove truly burdensome for the families with scanty resources for whom the program is basically aimed.

— In not having to go out, the mother can devote herself to taking care of the house and her other children; or, if she has a job, she is not forced to absent herself in order to take her child for treatment.

— Since the whole family can receive instruction, any member can effect the treatment, which may thus be provided at any time and for as long as necessary. This cooperation develops a sense of solidarity, compassion, and concern among all the members of the family group contributing to the patient's rehabilitation, with positive effects in terms of greater recovery in a shorter time.

In view of the program's complete success, with marked improvement among patients and great satisfaction among parents, we have decided to conduct a training course on this technique of integral neurological rehabilitation so as to multiply the number of patients assisted. The course has been designed for the personnel working in these fields in hospitals, clinics, and other institutions.

Annual Plan for Training Specialists for the Treatment of Children's Neurological Disturbances

Project Goal

To train specialists in specific techniques to conduct the examination and follow-up of patients already under treatment to give additional children the opportunity to be assisted by Dr Charles Solís during the first year of observation; these patients will then be passed on to the team which is to be trained simultaneously. The entire program will be supervised by Dr Solís.

Characteristics of the Course

Instructor: Dr Charles Solís, Director of the International Institute for Holistic Brain Development in Ashland, Oregon (USA).

Duration: One hundred hours, to be divided into four stages

Admission: The course will be limited to thirty students.

Methodology: Theory will be imparted through lectures, discussion in small groups, and workshops. Practice will consist of the care of the patients already being followed up and supervision of proposals for treatment in new cases.

Prerequisites: Candidates must have one of the following qualifications: *a*) technical training, *b*) a Masters in Physical or Occupational Therapy, *c*) de-

monstrated experience in the care of children with neurological problems as language therapists or educational psychologists They must be working at public or private institutions dealing with this form of treatment They must also commit themselves to offering their services to children from low-income families, who are to be assisted free of charge The first course will be made up of those who have completed preparatory studies and are interested in continuing

Program Evaluation and Follow-Up: A year-long program is projected consisting of

— workshops and seminars for new therapists to instruct parents and relatives on the treatment of children;

— evaluation and check-up of new patients by Dr Solís, who will then pass on to the group of course graduates;

— supervision each semester of graduates and their patients;

— four-hour meetings each semester for the overall updating and evaluation of the program by Dr Solís

General Coordination will be the responsibility of Patty Colmenares, a Physical and Occupational Therapist, who has done postgraduate work at New York University, the Hohenreid Clinic in Munich, and Rottenburg Hospital She is the founder of the Physical Therapy Service at the Caracas University Hospital, a professor at three Venezuelan schools, and a specialist in heart rehabilitation She is the first President of the Venezuelan Association of Physical and Occupational Therapists

CHRISTINE DE VOLLMER

President of the PROVIVE Association of Venezuela

Colón, Panama: General Report on the Healthcare Ministry

A Look at the Recent Past

Some years ago the void in the healthcare ministry began to be a source of concern for us in the face of the cruelest manifestations of poverty and marginalization in the lives of the poor in our Missionary Diocese of Colón.

The Holy See, in asking us to carry out a survey, was the first to inquire about the number of dispensaries, hospitals, medical centers, and other health services sponsored by the Church in Panama.

Unfortunately, our data were quite meager. Aside from some services offered by several religious congregations in keeping with their charism, for example, the Sisters of Charity and the Missionaries of Charity of Mother Theresa of Calcutta, among others, the Panamanian Church did not officially support health programs.

The Missionary Diocese of Colón thus began to take its first steps in this specific area of pastoral care.

Starting from the Ministry of the Earth, the meeting place of God with men and of men among themselves to execute the designs of creation, we took up the healthcare ministry as a response to the desires of Jesus: *"I have come so that they may have life in abundance."*

General Guidelines

1. To learn by experience, like the Good Samaritan, the Gospel significance of one's neighbor through pain.

2. Like the Good Samaritan, to seek to remedy maladies and sufferings.

3. In the face of personal limitations, to foster joint assistance by way of concrete pastoral care provided by a team.

General Objective

To spur the healthcare ministry as a response to the vital needs of our communities.

Specific Objectives

1. To unify the efforts of the various areas of the Diocese to achieve more efficient and global pastoral care in health.

2. To promote preventive care.

3. To promote curative measures.

4. To train health promoters to support the action by public medical centers.

5. To devote more spiritual attention to the suffering by way of the Anointing of the Sick.

Within this framework, approved at the annual meeting of the men and women Missionaries of the Diocese of Colón (1989), we started to work.

A Look at the Present Moment

In these four years of overall development of the healthcare ministry we have observed that we still have a long way to go. Although we are just beginning, we can cite important achievements.

a) A health ministry team made up of seven people to coordinate all health-related activities in the diocese.

b) Health Committees and Health Promoters in most rural communities that receive ongoing training through seminars and workshops.

c) We worked closely with the Ministry of Health during the recent cholera epidemic.

d) Latrine construction has been going on in different communities, and a network of sixty rural aqueducts is being built with the help of Manos Unidas and the EEC.

e) Household gardens and medicinal plants are a wonderful and encouraging reality in many rural communities.

f) In Colón we have a People's Clinic with two sections: general medicine and dentistry. Coordinated by Diocesan Catholic Charities, it is at the service of people with scanty resources who are not covered by the Social Security system.

g) In the near future we plan to create a National Alternative Health Care Network (RENASA) in conjunction with other Dioceses. The first meeting to give shape to RENASA has already been held, October 29-30, 1992.

h) We always attempt to combine the celebration of the Eucharist, where possible, or the celebration of the Word, with our health activities, so as to project in faith our Christian commitment to serve the health of our brothers.

We are aware of the fact that it is a long, difficult process, that our efforts are just a drop in the sea of poverty and marginalization in which our communities live, and that this situation does not seem to be improving, but is, on the contrary, deteriorating day by day as a result of certain neoliberal policies which overlook the urgent needs of the poor.

In the face of this discouraging reality, with our unshakable faith in the God of life, who manifested Himself fully in his Son Jesus, who "went about doing good," we continue to accompany the people.

Pontifical Council Activity

Talks

Chronicle

To Serve the Sick

Address delivered by Cardinal Fiorenzo Angelini for the Training Course on Administering Health Services organized by CARITAS of Italy and the Catholic University of the Sacred Heart in Rome May 9, 1993

I cordially greet all present and thank the organizers of this meeting for giving me the opportunity to deal briefly with a subject which, through a providential gift of God, has entirely absorbed my life as a priest and a Bishop.

I am firmly convinced that the ministry of service to the sick is at the core of the announcement of the Gospel, which in this field responds to the deepest and most universal request emerging from man's heart: the request for health, which is a request for life.

Having become incarnate "not to be served, but to serve," [1] Christ indicates in those suffering in spirit and in body not the "last," but rather the first in the Kingdom of God.[2]

In his ministry Christ gave priority to the sick and the suffering, to such a point that the whole Christian tradition and the liturgy itself call Him the physician of souls and bodies.

The Church, which received from Christ the specific commission to heal the sick,[3] has sought to implement rigorously this divine command since its inception.

The history of health care demonstrates that it was precisely the Church that initiated the socializing of medicine, in the broadest sense of this term, within the society where it spread.

The so-called Christian revolution was especially characterized by introducing into culture and practice a recognition of suffering and the priority importance of service to those suffering.[4]

The Church's missionary action as well, from the early centuries on, has constantly been linked to concern for the sick. The oldest hospital institutions, in every part of the evangelized world, bear the name "Christian." This occurred when Christianity spread in the Mediterranean basin and when it crossed the ocean to reach the New World.[5]

It is now taken for granted at all levels that the measure of civilization of a people consists of its capacity to show justice towards the weakest, the sick, the marginalized: those suffering in body and spirit. At the same time it is recognized that the clearest and most indisputable sign of progress in humanity is offered by scientific progress as a means to safeguard and recover health: to such a point that the degree of well-being in a country is evaluated by its inhabitants' median life expectancy.

Initially developed as charitable action, service to the sick has come to represent the primary exercise of justice. Indeed, the doctrine of love has laid the foundations for and matured awareness that service to those suffering is a prime duty of justice, which charity is not called to substitute for, but to sustain and enrich: a duty of all and not a discretionary option, a ministry not entrusted to simple spontaneity, but requiring demanding, ongoing preparation and training.

It may, however, happen, as has in fact happened, that a central, priority truth, precisely because it is such, is taken for granted to the point that it is neglected, even within Christian institutions.

An increase in this negative phenomenon may have been favored by both the phasing out in many countries of supplementary action effected exclusively by the Church in this field and the appearance of new, more complex problems within health care.

It should nevertheless be clearly stated that if the Church has been able to substitute for public institutions in care of the sick (and in many parts of the world it still does), these institutions will never be able to replace the action specific and pro-

per to the Church, which offers an integration of the moral, spiritual, and religious assistance which is an essential component of medical care itself.

With this clarification, it should at once be recalled that in the last fifty years the Magisterium of the Church has intervened increasingly to restore to this fundamental duty of evangelization its right and proper priority.

Pius XII was the first Pontiff to deal directly and profoundly with what are today called "the problems of bioethics." He may be regarded as the founder of that discipline, which examines and discusses the moral aspects connected with the development and applications of modern biology and medicine. But Pius XII, on a practical pastoral level, also attempted to renew the health-care ministry, beginning with Rome itself, which was the first diocese in the world to initiate what was at once extensive and coordinated action by the Church at medical facilities.

Thanks to the initiative of Pius XII, the Church's Magisterium in the second half of this century has provided orientations and directives of fundamental importance for solving moral problems linked to the exercise of medical research, science, and practice in their relation to moral postulates.

John Paul II is certainly the Vicar of Christ who, by a mysterious design of God, has been both an instigator of and a witness to a new, incisive, organic presence of the Church in the world of health policy and care, a presence understood to be a characteristic aspect of what he terms the "new evangelization." I shall limit myself to indicating the milestones of the Magisterium and ministry of John Paul II in this field.

In 1984 he published the Apostolic Letter *Salvifici Doloris* on the Christian meaning of human suffering. It is the first document of such breadth devoted to the subject of suffering.

The following year, on the same day, February 11th, the Holy Father instituted the Pontifical Commission (which later became the Pontifical Council) for Pastoral Assistance to Health Care Workers, a department which, illuminated by the doctrine on the Christian meaning of human suffering, is charged with promoting its application through the stimulus, coordination, and increasing involvement of health workers to serve life, from its conception to its natural decline in the time of illness, in accordance with the divine command to "care for the sick." Finally, on May 13, 1992, the Pope instituted the World Day of the Sick, to be celebrated annually, beginning in 1993, on February 11th, the liturgical commemoration of Our Lady of Lourdes.

This triptych is within the framework of the Pope's constant contacts with the world of suffering, the exceptional witness he has offered both after the serious assassination attempt of May 13, 1981 and during his

most recent illness These are events lived out in the loftiest supernatural spirit, to the point of transforming his bed of suffering into the most authentic and authoritative Magisterium on the truth of the salvific value of pain and suffering

In its eight years of existence, the Pontifical Council for Pastoral Assistance to Health Care Workers has worked worldwide and in the universal Church in ongoing action involving encouragement, openness to the entire health community, and dialogue with all responsible for care, regardless of ideological, political, and social differences The Council which I am honored to head has always and everywhere sought and offered concrete collaboration At the root of this general action has been the well-grounded conviction that interest in health-related subjects and problems constitutes an extraordinary force drawing people together and thus fostering harmony and peace among peoples.

Among the special initiatives of the Pontifical Council for Pastoral Assistance to Health Care Workers, I would like to recall the following:

— the realization of the first census in the history of the Church of Catholic healthcare institutions around the world;

— successful efforts in requesting that every Bishops' Conference name one of its members to assume responsibility for pastoral care in health;

— the joyful recognition (expressed by the President of the Council at recent Synods of Bishops) of the acceptance of concrete proposals for the healthcare ministry (let it suffice to recall the introduction into the concluding *Declaratio* of the Special Assembly for Europe of the Synod of Bishops of the unanimously approved proposal stating, "The right to the safeguarding of health and, insofar as possible, to its recovery, must be firmly ensured The commitment of all of society and the pastoral concern of the Church must be directed towards everyone who suffers, especially those who are afflicted by the illnesses of our time It is necessary for health workers to have suitable formation in moral doctrine and the problems of bioethics"); [6]

— the publication over the last seven years (in separate editions for five languages) of the journal *Dolentium Hominum Church and Health in the World* appearing three times a year, for the formation and information of health workers, including the Pope's and the Holy See's teaching and directives, relevant contributions on the most serious problems in medical ethics and pastoral care in health, and updating on the activities of Catholic healthcare institutions around the world;

— the organization of eight International Conferences (the eighth will take place this fall, and the theme is "The Child Is the Future of Society"), which have dealt on the highest scientific and pastoral level with the problems of pharmaceuticals, humanity medicine, longevity and the quality of life, AIDS, the human mind, drugs and alcoholism, and the disabled (Each of these International Conferences, whose complete *Proceedings* have been published, has concluded with an address by the Pope, who offers a clear orientation today for both healthcare and pastoral workers on the specific topics involved);

— participation, by way of concrete proposals, in the leading international initiatives on health policy and care emerging around the world in the last eight years;

— stimulation and support of the numerous voluntary associations and organizations, along with other contributions, such as the particularly significant effort at encouraging religious vocations to serve the sick.

I have limited myself to tracing the main outlines of an involvement which by its very nature has a thousand other facets, as you can well imagine

To conclude, allow me to stress two concepts

Firstly, the Church is and seeks to be close to everyone working in the world of health policy and care; policy encompasses decision-making, legislation, and health planning proper to each country, and care involves all aspects of prevention, diagnosis, therapy, and rehabilitation for the best psychophysical equilibrium of the person By doing so, the Church remains at the side of the sick in a useful way.

The Church offers the largest effective healthcare presence in the world With nearly thirty thousand health institutions, the Church is able to ensure pioneering and innovative action to improve health care, especially in the face of the new illnesses of our time.

Secondly, I would like to emphasize that the Church, as the Holy Father, John Paul II, has repeatedly affirmed, regards service to the sick as a most noble profession, and at the same time a vocation and a mission The three aspects are integrated: they are three facets of a single diamond.

The finest, most highly qualified professional training needs to be supported by a vocation to service experienced as a mission to be fulfilled The holy doctor Giuseppe Moscati said that science alone is not enough where charity is lacking to sustain it In addition, real professionalness itself brings out the duty of justice the health worker at every level is called to perform, including administration and, if you will, health policy.

For every faithful Christian and every human being the example of the Good Samaritan always expresses the norm for moral behavior, justice, and charity towards all, without exception The nobility of intentions is not sufficient. It must be accompanied by coherent witness.

The road to be traveled is still long, for awareness of the importance and practical dimensions of this calling is still weak

To be effective, the words and directives of the Church must be known, meditated upon, and examined deeply, and put into practice by health workers, as individuals and associations, first of all, however, by the Bishops and by priests, who must offer a good example It is not true that the sick are automatically served and assisted as a matter of duty, and it is not

true that care of and service to the sick from a pastoral (and, particularly, sacramental) standpoint are easy. Specific training and pastoral practice and experience from the beginning of priestly formation in seminaries and religious institutes are needed.

In gathering into one volume two years ago a series of papers on medical-ethical and pastoral problems, I entitled the collection *That Breath Upon the Clay*

Our world of health care, like primordial matter, is clay which must be shaped by solid faith in life as a gift of God, by consistent adherence to the Christian message which we say we profess, and by credible witness to justice and love in serving those who suffer in body and in spirit: the sick, who represent Christ Himself The Face of Christ must be seen and admired by the eyes of faith in the faces of the ill It is by doing so that one may come to understand and supernaturally live out the extraordinary and mysterious charism of suffering, which can and must culminate in the search for God, the Creator and Redeemer of life.

[1] Cf. *Mt* 20:28.

[2] Cf. *Mt* 5:4: "Happy those who mourn: they shall be comforted;" 25:45: "I tell you solemnly, insofar as you neglected to do this to one of the least of these, you neglected to do it to me."

[3] *Lk* 9:1-2: "The he called the Twelve and gave them power and authority over all demons and to heal illnesses And he sent them to announce the Kingdom of God and to heal the sick."

[4] JOHN PAUL II, Apostolic Letter *Salvifici Doloris*, 30: "Christ has at once tought man to do good through suffering and to do good to those suffering Under this twofold aspect he has revealed the meaning of suffering thoroughly"

[5] Cf. F. ANGELINI, *Early Evangelization in Latin America and the Church's Attention to the Sick* (Rome 1992).

[6] SYNODUS EPISCOPORUM Coetus Specialis pro Europa, *Declaratio*, 10

The World of the Elderly

Address by Cardinal Fiorenzo Angelini at the Meeting on "Longevity and Society" organized by the OASIS Association of Our Lady in Troina Italy September 16 1993

In extending my best wishes for the sessions of this meeting, I cordially greet the authorities attending and all the distinguished participants I address a special word of appreciation to Father Luigi Ferlauto, President of the OASIS Association of Our Lady and to his staff, who have so carefully prepared these days of reflection

It is certainly significant that the subject of this meeting should be considered and examined in a place where there is an effort to implement in concrete terms your commitment to providing the elderly with the best care

There is a special reason for which I was pleased to be invited to open your Conference.

The document on "Intergenerational Solidarity" included in the elegant brochure containing the program for this meeting shows two elderly people and two children; in the background there rises up, for all of them, a tree which I fondly interpret to be the "tree of life."

In two months, at the Vatican, under the auspices of the Pontifical Council for Pastoral Assistance to Health Care Workers, which I am honored to head, our Eighth International Conference will be held; this year, on the eve of the celebration of the International Year of the Family, the theme will be "The Child Is the Future of Society."

This is an event which, as the experience with prior annual International Conferences has demonstrated, has a worldwide impact. The messages with which the Holy Father has always closed this symposium now constitute valuable reference points for medical science and ethics

What is more, one of the first topics considered was also that of "Longevity and the Quality of Life," the subject of the Third International Conference, held in November 1988 And it was precisely on that occasion when the Holy Father stressed, as an indispensable requirement for the quality of life of the elderly, the need to relate all care and enrichment to the fundamental principles of the sacredness of human life, the dignity of the human person, and the inviolability of the person's freedom (cf. *Proceedings of the Third International Conference*, November 8-10, 1988, in *Dolentium Hominum Church and Health in the World*, vol IV, no 10/1, 1989, 7).

Allow me, then, to link the topic of this meeting in ideal fashion with that of the coming International Conference on children.

Today people like to speak of "the world of the elderly," "the world of the young," "the world of children," and so on It is proper to speak of "worlds," for worlds exist and have life insofar as they are connected with a star. Worlds, or "planets," are heavenly bodies, but are flameless, shining with reflected sunlight; they revolve around the sun and at the same time rotate on their own axes, with the characteristics proper to each.

Just as, in our planetary system, each sphere vitally relates to the sun, so each age of human life refers to life as a whole.

The ever more accentuated exaltation of the different ages of life resolves itself, in the final analysis, into a greater consideration of the value of life in its totality. Indeed, even from an exclusively scientific standpoint, personal human life is not the arithmetical sum, so to speak, of

adolescence, youth, adulthood, and old age, but rather something unitary which, in each of its phases, presents itself with a character of entirety or wholeness.

The very consideration of the different *ages* of life demands a clear notion of *life* as such; I am referring to life *without age*. And I am pleased to find among the titles of the papers to be read during this meeting the following: "There Is No Old Age and Never Has Been" and "The Old Age of the Young."

If, at least as a methodological criterion, we assume that life represents a value, we must recognize that it is a global, primary value, inasmuch as no other value is conceivable without reference to the value of *life*. And when we speak of biological and psychic life, of cultural and social life, of spiritual and religious, human and divine, marital and family, economic, moral, individual, and community life, and so on, we reflect the indispensable exigency of relating all that we know and love to the notion of life.

No age of life is dignified unless all are, both on a strictly personal level, as I mentioned, and socially.

The elderly person was once a child, an adolescent, a youth, and an adult; old age and longevity are, in turn, potential and to be hoped for in the child, the adolescent, the youth, and the adult.

The child is the future of society since the phases of his or her existence are a gradual maturation in growth. And perhaps never before have the elderly been present in the society of our country as they are today, but they are present because they were children, adolescents, young people, and adults.

In Italy today the population at retirement age numerically surpasses the active population. The imbalance does not result only from an increase in life expectancy, but from the gradual reduction (indeed, to the level of zero) of the birth rate. For want of children hundreds and thousands of nursery and elementary schools are being closed, and this prospect is now extending to middle and high schools. The statistics are worrisome and reveal a disharmony which translates into social dislocation; there is an increase in parents without children and grandparents without grandchildren, for there is an attempt not on childhood and youth in themselves, but on life and, along with life, on the social fabric. The individual planets (to keep up the metaphor) run the risk of falling into darkness, for there is an effort to extinguish the sun of life illuminating them. The Bible's presage seems to have become anachronistic: "The crown of the elderly is their children's children; the children's glory is their father" (*Pr* 17:6).

The harmonious unity of human life (indeed, of society) must be recovered, a unity which is not the uniformity or homogeneity of its components, but convergence in diversity.

A polyphonic choir is such if all the voices contribute to it, from treble to tenor, baritone and low-pitched ones.

The parable of life follows the course of a choral performance in which to the number and quality of the voices there must be added the harmony of their song.

Society needs this harmony, which life as a value distributes throughout the span of human existence, with unmistakable characteristics, where one relates to another, however, and needs the other. The desertifying aggressions against life which in our society are blotting out childhood can only involve the elderly, too, who already perceive a growing solitude and painful lack of motivation.

St. Augustine writes, "May our childhood be innocence; the early years, modesty; adolescence, patience; youth, virtue; adulthood, merit; and old age, nothing but an immaculate, wise intellect" (*Sermon 28: Infantia nostra innocentia sit, pueritia sit reverentia, adulescentia patientia, iuventus virtus, senium meritum, senectus nihil aliud quam canus sapiensque intellectus*).

As always occurs providentially, however, the multiple problems posed by this social dislocation have increased awareness of the urgent need to solve them.

The road to be traveled cannot, however, be limited exclusively to dealing with so-called specialized problems, but must recover what the Pope calls a "culture of life," to be set against the intrusive "culture of death." The culture of life is to be life's servants, not its arbiters, from its conception to its natural close. The culture of life is to foster, defend, and exalt life throughout its span and in all human beings. The culture of life is to avail oneself of the experience acquired with longevity to transform it into a patrimony of solidarity, harmonious community, and constructive proposals.

To know a road adequately one must first have traveled it. Whoever has the gift of a vigilant longevity knows this route; the Bible thus invites us to frequent the wise man's house to the point of wearing out his doorstep (*Si* 6:36); and in another passage states, "The way of the just is like the light of the dawn, which grows brighter and brighter until the fullness of day" (*Pr* 4:18).

All the problems of longevity, and particularly the social ones, should be dealt with and solved in the light of a full, enthralling vision of life which stimulates us not to dishearten us afterwards, but to help us discover its inestimable value.

What the Church Expects from Us as Persons Consecrated to Hospital Care

Opening Address by Cardinal Fiorenzo Angelini at the St. John of God Brothers' Course on Pastoral Care in Health, Rome, November 7-14, 1993

First of all, I welcome and greet all the participants in this Course on Pastoral Care in Health, the organizers, the speakers, and those who will offer their contributions in science and experience.

The world of pastoral care in health, in fact, is our world; it is as boundless as human pain in its multiple manifestations: physical, psychic, moral, and spiritual. Personally, however, I have always preferred and prefer to speak not, indeed, of the world of suffering or pain, but rather of the world of health policy and care, precisely to stress the constructive position which, by vocation and mission, we are called to take as regards human suffering.

The Church, as an institution and as the People of God, as a hierarchical structure and as a prophetic community, sees its largest, most conspicuous, and most expert forces committed to this world of health policy and care.

There are about 30,000 Catholic healthcare institutions scattered around the world, without counting the numberless outpatients' departments and medical facilities for the sick which cannot possibly be included in a census; there are tens of thousands of men and women religious engaged in the health apostolate. In the territories where the Church is initiating its presence, the outpatients' department, the clinic, and attention to the suffering and needy chronologically precede building places of worship; before bringing bread, the Church often brings medicines which are no less indispensable than food.

This indisputable fact is confirmed by history: to the Church is due the introduction of the socialization of health care; from the Church alone came the struggle against and remedy for epidemics; the first hospitals were built by the Church, and even today, in many developing countries the Church not only fills gaps in the health field, but is sometimes the sole agency taking care of the sick.

Against the "new maladies" afflicting mankind, like drug addiction and the spread of AIDS, the first integral and constructive reaction came from the Church.

When, in 1989, representing the Holy See, I took part in London in the Summit of 148 countries seeking a concentrated, coordinated reaction to the threat of AIDS, it was not hard to censure the limits of a response dissipating itself in the illusory recourse to generalized contraception, to the point that an entire floor of the building where the summit was being held was merely an almost grotesque exhibition of the most incredible variety of contraceptives.

The best pages related to Christ's mandate, the history of the Church's early preaching

and her history over two thousand years have been written by serving the needy and the suffering.[1]

On the basis of this premise, at once doctrinal and historical, the question "What does the Church expect from us as persons consecrated to hospital care?" takes on meaning.

Allow me a clarification within this question. I would not merely say "as persons consecrated to hospital care," but rather "as consecrated persons who identify with the charism of hospital care," which for the sons of St. John of God is the object of a vow.

Being *consecrated* persons involves a state of life which is stable and recognized by the Church,[2] "constituted by the profession of the Gospel counsels."[3] This profession of the Gospel counsels requires a *more intimate* consecration,[4] for consecrated persons, taking up the indications and impulse of the Holy Spirit, seek to follow Christ *more closely*, living in the fullness of charity, to announce the Kingdom of God on earth more vitally and effectively.[5]

The history of men's and women's religious institutes is the history of this witness to full consecration, lived out according to different charisms in response to the demands of the times.[6]

We must acknowledge, however, that the charism of hospital care, under the complete notion of which the tasks of pastoral care in health fall, is perennially up-to-date; the answer to the question contained in our topic derives therefrom. It is a current interest regarded by the Holy Father today as the "fundamental mission" of the Church.[7]

At the root of the nature of the response which, as consecrated persons, you are called to give to the Church's expectations is, first of all, the fullness with which your *religious consecration* is lived out.

The experts who will speak at this Course will dwell upon the varied aspects of pastoral care in health which you are engaged in fulfilling.

I would, however, like to stress three aspects which I regard as basic and urgent and which I find, among others, also

stressed in the *Constitutions* of the Hospitaller Order of St. John of God.

They are certainly not the only aspects which reflect the corresponding expectations of the Church, but I feel they are particularly timely at the moment in history we are living through.

Vow of Hospital Care and Evangelization

The first aspect concerns the relation between the practice of the vow of "hospitality" and evangelizing action.

Your *Constitutions* strictly link the implementation of your charism to evangelization.

You seek to live the vow of hospitality "as an announcement and sign of the new and eternal life obtained by the redemption of Christ"; that is, with your lives "given to the love of God in serving the poor and the needy, [you] announce the Kingdom as Jesus did." [8] A commitment, as your *Constitutions* specify, which might even require the sacrifice of one's life,[9] as occurred, for instance, with your numerous recently beatified brothers slain while still very young during the Spanish civil war.

Pastoral care in health is evangelization after the fashion of Jesus, who devoted Himself preferentially to the weak and the sick in spirit and in body,[10] to the point of identifying Himself with them and asking us to do so as the parameter for judging our conduct.[11]

It is difficult for us to take seriously this teaching by the Lord, so clear that it requires no special exegesis.

For you, spiritual sons of a Saint who loved to call himself "nothing," this style of Jesus is the object of a vow, that is, of a "deliberate and free promise of a possible and better good made to God." [12]

The observance of this vow is your way of announcing the Gospel, one of the most effective and credible ways, which can be immediately verified.

A way of evangelizing others which also translates into evangelization of ourselves, for in the weak and suffering the very Face of Jesus is recognizable, as the Lord assured us.

An evangelization also constituting your initial and permanent formation.[13]

And I shall state that I was particularly struck by finding in your constitutional text the recurrent concept of "happiness" and "joy" in relation to the exercise of your ministry and apostolate.

The religious vocation comes from God; to respond to it is to listen to the Word of God and find therein the deepest serenity, peace, and joy.

This is what the Church expects from you: for you to live in joy, even if the vow which has given a direction of definitive dedication to your lives is not easy and must be fulfilled each day.

The Courage of Witness

Secondly, the Church expects the courage of witness from you.

Your special religious consecration commits you "to defend and watch over the person's rights to be born, to live decorously, to be cared for in illnesses, and to die with dignity." [14]

It is recognized that the Church, especially in our time and through the impulse impressed upon it by the Holy Father, John Paul II, is at the vanguard in defending basic human rights, which are summarized in the right to life and to its dignity.

In this mission, the Church expects from you living witness, front-line action.

In a time like ours, beset by so many fears and oppressed by so many nightmares, the courage must be recovered which comes to us from faith and from the promises of Christ.

In the most recent years, even within ecclesiastical institutions, discussion has been preferred to action, speech to deeds, and the multiplication of doubts to trust in certainties.

Right and proper openness to others has in the end spurred us to be closed in ourselves. Legitimate searching for the most suitable methods seems to have introduced distinctions and discrimination into the concept of goodness, almost as if there were a goodness of yesterday, today, and tomorrow, and not a permanent goodness.

We know everything about the problems to be faced and solved, but we do not know how to solve them.

One reason for this situation should be sought in the loss of some essential, key principles which are the basis for a clear conception or vision of life.

Among these principles, precisely that of the person's rights to life and to its dignity is predominant.

All of us are called to be close to the human person in defending his right to life and to a worthy life, for all of us believe in life as a gift of God. A gift to be defended, but also to be discovered at every instant in our neighbor, especially in those impotently witnessing their own lives being attacked by illness, injustice, selfishness, discrimination, and hatred.

Gospel *compassio* is not compassion as a manifestation of philanthropy, but a *sharing* in the human condition, a capacity to recognize in our brothers' and sisters' lives the life of Christ, the life that is Christ.

Studies and statistics demonstrate that many of today's young people love total choices, forms of radical dedication. It is surprising that in this context religious and priestly vocations have for decades been marking time in so many parts of the world.

And yet, what choice is more global, more radical than that of being utterly close to others to make them partakers of Christ's redemption through service to life? Why, then, are so many religious institutes even afflicted by the fear of an irreversible decline?

What is it that does not make our and your witness sufficiently credible?

I have spoken of courage, but I would like to add the concept of enthusiasm which must accompany your work, the exercise, the practice of your hospital vocation.

The world has much greater need of witnesses than teachers.

What pastoral activity is more vocational than pastoral care in health? If you are convinced of this, it will be of only relative importance to adopt one method or another, avail oneself of one aid or another. You are

called to be the first instrument, the first aid. It is this which the Church expects from you

An Intense and Rigorous Spiritual and Inner Life

Finally, the Church expects from you an intense and rigorous spiritual and inner life.

Whoever is active on the frontiers of evangelization has an arduous task, but also the chance for necessary and daily observation. Alone and exclusively with onès own strength it is not possible to keep faith with the commitment taken on with religious consecration in the most delicate sector of health policy and care.

I am not referring so much to the temptation to surrender as to the risk of habit, of routine, of letting oneself go, of falling into that spiritual indolence which turns into complete pastoral sterility.

The days of study before you are rightly marked by intense moments of liturgical prayer centering on the Eucharistic celebration.

There is much talk today, and properly so as well, of the need for formative, and I would add, professional updating. But there is also a need for constant updating of our inner life, a renewal implemented with prayer, sacrifice, renunciation, simplicity of life, and abnegation. We must rediscover the ascetic prescription of *nudus nudum Christum sequar*.

How often, alongside the suffering, we gain firsthand experience of the limits of our strength! How often we deeply feel the need for intervention by a higher force coming to our aid.

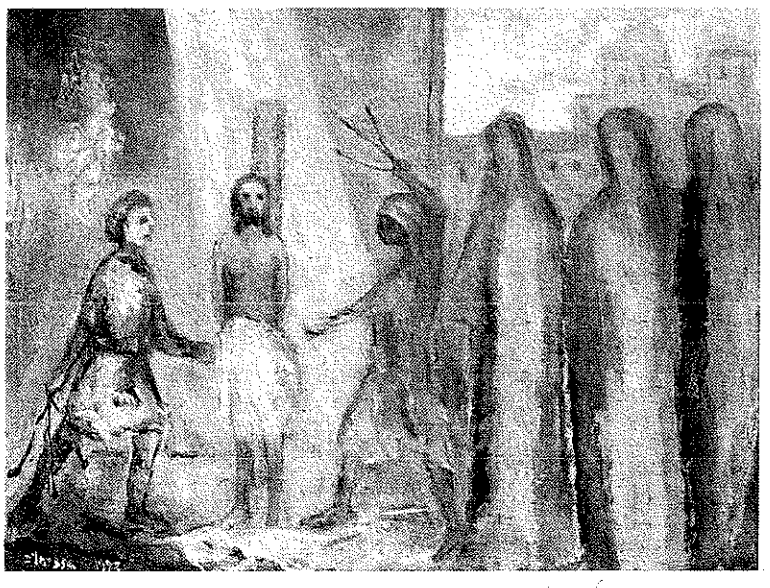
Your *Constitutions* recall this quite clearly, where we read, "We renew the awareness of our vocation in the celebration and contemplation of the mystery of Christ. The Word of God and the Eucharist occupy a central place in our life; we contemplate Jesus in his way of dealing with the sick and principally in his passion and death, the supreme manifestation of his love for man. This fortifies us in charity and stimulates us to carry out our mission by imitating the life of our Savior."[15]

Community and personal prayer is the first means of pastoral care in health: a means which your *Constitutions* invite you to see mirrored in the simplicity, generosity, dedication, and faithfulness of Our Lady.[16]

In wishing you the best possible realization of this Course, I invite you to reflect on these brief reminders, for I am convinced that from them there may flow a growing love for your vocation, which you must regard as a gift, indeed, a privilege. To have the opportunity to offer the suffering and the needy help which is not illusory is a gift; I would even call it extraordinary good fortune, if we remove from this term every trace of chance.

Every day I thank God for this gift, and, perhaps for this reason (and whoever knows me must also be tired of hearing me repeat it), I love to confess openly that if I were reborn once or ten, one hundred, or a thousand times, I would again embrace the priestly vocation. And I believe I would do so again because the Lord's having assigned me for so many years to the ministry of pastoral care in health has helped me to discover and grasp with utter clarity the grandeur and beauty of this vocation.

With simplicity and humility, this is my wish for all of you as well.



[1] "For two thousand years there has lived and thrived in the soul of the Church the sentiment which spurred and still spurs, to the point of charitable heroism, the farming monks, the liberators of slaves, those caring for the sick, and those bearing the message of faith, civilization, and culture to all generations and all peoples, so as to create socila conditions capable of making possible for all a life worthy of men and Christians" (Pius XII, *Allocution of June 1, 1941*).

[2] Cf. *Lumen Gentium*, 42-43; *Perfectae Caritatis*, 1

[3] *Ibid.*, 44

[4] *Perfectae Caritatis*, 5

[5] *Code of Canon Law*, canon 573

[6] "History attests to the great merits of the religious families in propagating the faith and in forming new Churches, from the ancient monastic institutions and medieval orders to the modern congregations" (John Paul II, Encyclical *Redemptoris Missio*, 69).

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

[8] Hospitaller Order of St. John of God, *Constitutions*, article 21

[9] *Ibid*, no 22.

[10] Cf. *Mt* 9:12, *Lk* 18:15-16, *Mt* 8:16-17.

[11] Cf. *Mt* 25:34-35

[12] *Code of Canon Law*, canon 1191, § 1.

[13] "The hospital vocation we have received is a gift which develops in us to the extent that we respond every day to the invitation of God, who calls us to identify with Christ in love for men and especially in serving the sick and the needy" (*Constitutions*, article 53)

[14] *Ibid.*, 23

[15] *Ibid*, article 4

[16] *Ibid*

Programming and Animating Pastoral Care in the Health Field

Lecture delivered by Rev. José L. Redrado, O.H., Secretary of the Pontifical Council for Pastoral Assistance to Health Care Workers, at the Course on Pastoral Care in Health organized in Rome by the St. John of God Brothers, November 7-14, 1993.

I. Premises to Be Taken into Account in Pastoral Programming and Animation

1. *Attention to the Challenges the Health Field Presents for the Church*

We have stated and heard on innumerable occasions that the health field is a complex area requiring specialized pastoral care.

Pastoral workers should begin by situating themselves, that is, knowing where they are and what the environment is like in which they are going to work.

In broad outlines, I would like to point out some challenges which the pastoral worker should bear in mind, in terms of both outlook and programming.

The Main Challenges [1]

a) The secularization of medicine, with a consequent loss of spiritual appeal and attractiveness for health personnel. People do not approach the sick today mainly out of a vocation, but for other reasons.

b) The dehumanization of medicine is connected with a hypertrophy of technology. Man has been displaced by the machine, and a technical mentality has been created, where impersonalness, stress, and feeling like a robot impede approaching the patient and carrying out integral care. Attention is becoming increasingly technical and less human.

c) A lack of ethical preparation in professionals affects negative criteria on subjects of such importance for life as genetics, euthanasia, abortion, and death, or on areas related to the health professions: responsibility, respect, justice, loyalty.

d) Health topics are socially important and often serve as a political platform rather than as a solution to concrete realities. Government policy and high health costs push the Church out of this field. Governments are increasingly entering health care as a way to control citizens.

e) The complexity of the health field sometimes makes it hard to distribute technical, human, and economic resources.

f) Most of the moral problems the Church must face today arise in the area of health care.

g) The aging of the members of most religious institutes results in a withdrawal from active employment [2]

h) In view of the rapid, profound changes undergone by health care and a lack of adaptation to this pace and standard by a good many religious institutes in health work, there has not been a qualitative leap enabling them to cope with new demands.

2. *Illness: An Appropriate Time for Evangelization*

First of all, it is appropriate for *patients themselves*, since their new life situation is totally changed, perhaps shifting from immense activity to a complete standstill, from an absence of free time to all possible time to think, evaluate, review, and "live."

The patient is surrounded by the *family*, which shares in and undergoes the same reality; the family may find room to renew its faith and love.

It is also an appropriate time for the *Christian community*, which at that moment can exercise the values of solidarity, acceptance, and faith shared in prayer.

It is a special time for those working at the hospital, particularly *pastoral workers* and all Christians, since the patient is a sounding board for many problems, the opportunity for an apostolic awakening.

But it is, above all, the time of God. God has his moments, his designs, his means. God frequ-

ently passes through man's life, but man is sometimes distracted; now, in illness, man can hear Him without so much noise From experience we know that for many people illness has been the appropriate time to change their lives, to feel closer to God, who passes, again and again, not to judge us, but to save us

3 *Five Guidelines for Pastoral Renewal* [3]

a) Long live man! We must move from pastoral care assisting people towards a "good death" to care which helps them towards a "good life" (to live through health, illness, suffering, and death meaningfully)

b) We are all responsible! We must move from "clericalized" pastoral care to "ecclesial" care, the task and responsibility of the entire People of God

c) The patient is someone, not something! We must move from pastoral care "reifying the patient" to care which "personalizes" the sick

d) The neediest patients are outside the hospitals! We must move from pastoral care which is exclusively hospital-centered to care which also extends beyond the hospital

e) Without coordination there is no effectiveness, nor does the face of the Church become clear We must move from unorganized, isolated pastoral care to planned, coordinated care

II. Two Models for Pastoral Care in Health: Jesus of Nazareth and the Apostolic Community

1 *Jesus of Nazareth*

a) Jesus presents Himself as a model: "I am the way, the truth, and the life" (*Jn* 14:6); "I am the good shepherd I know my sheep and they know me" (*Jn* 10:16)

b) Jesus is in *full communion* with the Father: "My food is to do the will of the one who sent me" (*Jn* 4:34) And on many occasions he resorts to *prayer*: Jesus withdrew to solitary places to pray (*Lk* 5:15-16); He spent the night in prayer (*Lk* 6:12)

c) His pastoral style does not involve imposition, but joins with others, accompanies, explains, enlightens, converts, and celebrates Cf the magnificent example of the disciples on the Emmaus road and Jesus' pastoral action (*Lk* 24:12-25)

d) In pastoral care, Jesus uses the *word*; the Evangelist Matthew narrates for us at least five major sermons forming part of Jesus' evangelization: the sermon on the mount (*Mt* 5-7), the missionary sermon (*Mt* 10), the sermon with parables (*Mt* 13), the rule for the community (*Mt* 18), and the eschatological sermon (*Mt* 24-25)

e) Above all, Jesus used *gestures* in his pastoral activity: solidarity with the marginalized, acceptance, forgiveness, and curing the sick

The sick and the marginalized are the privileged targets of Jesus' pastoral attention In this area, in particular, his words are abundant, and his gestures, provocative

– The Gospel tells us that Jesus *traveled throughout Galilee*, teaching and healing; his fame spread, and they brought Him the sick, and He cured them (*Mt* 4)

– The people were *amazed and exclaimed*, "He has done everything well: He makes the deaf hear and the mute speak" (*Mk* 7:37)

– Clearly, *Jesus did not cure everyone, but He communicated salvation to everyone He met*, including many paralytics, deaf and blind people, and lepers (*Mt* 8, 9, 11; *Mk* 5; Jn 5)

– *Jesus words are surprising*: "I want it; be clean" (*Mt* 8:3); "Fear not, have faith and that alone" (*Mk* 5:36); but *his gestures* and *his silences* are especially so: the way He sees, attends, respects, and pauses (*Jn* 8:1-11, 9:1-140; *Mt* 9:18-26) These words and these signs provoked wonder and admiration

f) *Jesus instituted the first pastoral team* Jesus was not a solitary evangelizer, but called certain disciples, brought together a group of followers, trained them, and then sent them to announce and promote the kingdom of God, proclaiming the word and performing signs of healing

"He called together the Twelve and gave them power and authority over demons and to cure illnesses and sent them to

preach the kingdom of God and bring health to the sick" (*Lk* 9:2, *Mt* 10:1)

Jesus' pedagogy has three parts.

1) The call (*Lk* 6:12-16, *Mt* 10:1-4).

2) The process of *training* the group, in which each manifests himself as he is: Peter, the head (*Mt* 16); Philip, the distracted one (*Jn* 14:8); John, the beloved disciple (*Jn* 13:23); the desire of all to be first (*Lk* 9:43-50, *Mk* 10:35-45). Little by little Jesus fulfilled the role of the pedagogue, the educator: teaching them to pray (*Lk* 11:1-3), especially explaining the parables to them (*Mk* 4:1-20), leading them through certain experiences, such as Tabor (*Lk* 9:28-36), the mission of the Twelve, and the sending of the Seventy-Two (*Lk* 9:1-6, 10:1-20), stirring their enthusiasm and warning them about hard times: carrying the cross (*Lk* 9:23-27), undergoing persecutions (*Jn* 15:20), and the need for perseverance until the end (*Mk* 13:13).

3) Finally, He *sent them*: "Receive the Holy Spirit, go, and baptize" (*Mt* 28:16-20); and they departed and traveled through the villages, evangelizing and healing everywhere (*Lk* 9:6), and they cast out many demons and anointed many sick people with oil and cured them (*Mk* 6:13).

2 *The Apostolic Community*

The apostolic activity of Paul and the Twelve was grandiose, as narrated to us by the Acts of the Apostles (see also John Paul II's Encyclical *Redemptoris Missio*, nos. 24-27). In connection with the teachings of Jesus, they announced the Good News and cured the sick.

"The Church was increasing; many believed in the Lord. They would take the sick out into the streets, placing them on stretchers so that, when Peter passed by, his shadow would fall upon them and they would be healed of their ailments. And many came from Jerusalem and other nearby cities and brought the sick and those possessed by unclean spirits, and they were all cured" (*Ac* 5:14-16). The Church was always aware of her mission; together with all these forms, there appeared a modality which was the institutionalization of the hospital in the Church by means of the deacons.

The Acts of the Apostles (6:1-7) narrates the election of the first seven deacons, whose task would be to serve the indigent (2:45, 4:35) so that the Apostles need not abandon the ministry of the word (6:2).

To the Church was due the entire organization of hospitals and residences for pilgrims, the sick, and orphans.

Councils and synods, like the gatherings in Carthage (309) and Tours (567), would order the establishment of inns alongside churches and the obligation to look after the needy, the sick, and widows.[4]

III. To Evangelize: The Specific Mission of the Church

1 *Awareness of This Mission*

The Church exists to evangelize: to announce and communicate the Good News, as the continuation of the words and gestures of Jesus (*Mt* 28; *EN*, 13,14).

"To evangelize is the Church's reason for existence, and if this is her specific mission, all of her members must have a lively awareness of their responsibility for spreading the Gospel" (*Message by the Pope for World Mission Day*, October 21, 1990).

The "care of the sick" has been entrusted to the Church as a community of believers through the apostolic mandate. This concern for curing the sick is inseparable from evangelization.

The very tradition of the Church teaches through the Magisterium:

— that service to the sick is an integral part of her mission (Motu Proprio *Dolentium Hominum*, no. 1);

— that the Church seeks an encounter with man, in a special way along the road of suffering: "Man is the way of the Church" (*Salvifici Doloris*, no. 3);

— that caring for the sick is a *diakonia* of the local and universal Church, and in this ministry she does not limit herself to her faithful, but opens herself, it must be added, out of faithfulness to the Gospel, to everyone who suffers (*Lk* 10:25-37);

— that the care of the sick refers to man in his spiritual-somatic unity (Motu Proprio *Dolentium Hominum*, no. 2);

— that it is, therefore, the obligation of the Christian community to help the sick to free themselves from everything preventing suffering from being a "redeeming force" for them and others (*Salvifici Doloris*, no. 1);

— that the care of the sick is an ecclesial *diakonia* which perfectly expresses the Church's essence as a "universal sacrament of salvation" (*Lumen Gentium*, no. 1).

We see that this pastoral practice with the sick has always been vitally present throughout the history of the Church. Sometimes it has been a labor of *filling gaps*, serving with Church institutions where a void existed, that is, where the State did not reach a need. On other occasions, the Church has offered the State, when already present, *co-*

operation as a sign of quality in care of the sick. But the Church must always carry out her "*specific mission of pastoral presence*"; in continuing the work of Jesus, she is sent to say a word, offer a gesture to everyone, but especially to the weak, the elderly, and the sick.

This is indispensable; it is her mission. Care of the sick by the Church is not a counsel, but a true mandate given by Jesus.[5]

2 *Towards a New Evangelization*

Pope John Paul II, in the Encyclical *Veritatis Splendor* (August 6, 1993), refers to his idea of a "new evangelization" launched ten years ago in an address to the Bishops of CELAM (May 9, 1983). The following quote is from the Encyclical (no. 106):

"Evangelization is the strongest and most exalting challenge which the Church has been called to face since her origin. In reality, this challenge is posed not so much by the social and cultural situations she encounters throughout history, but by the mandate of the Risen Jesus, who defines the Church's very reason for existence: 'Go throughout the world and preach the Gospel to every creature' " (*Mk* 16:10).

"Nevertheless, the time we are living through, at least within some populations, rather projects the sign of a major provocation towards a 'new evangelization,' that is, towards announcing the Gospel, ever new and ever bearing novelty, an evangelization which must be 'new in its ardor, in its methods, and in its expression' "

Five years later, in Salto, Uruguay, while explaining the meaning of those phrases, the Pope himself stated,

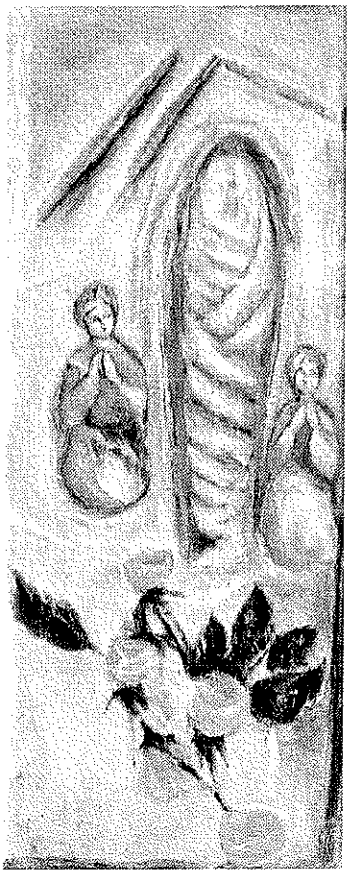
"Evangelization will be new in *ardor*, if in the measure in which it is implemented, you increasingly reinforce your union with Christ, the first evangelizer; ... it will be new in its *methods* if each member of the Church becomes an actor in spreading Christ's message; ... in order for evangelization to be new in *its expression* as well, you must carefully heed what the Lord may suggest at any moment "[6]

All evangelizing action must always begin with inward action; that is, the evangelizer must first have evangelized himself, undergone the experience of an encounter with Jesus the Savior (*EN*, 24), since evangelization is, above all, communication of an experience; it is not a matter of professional activity, of ideological propaganda, or of philanthropic service; it is, above all, a living witness. To convey doctrine convincingly, witnesses are needed.

We must avoid apostolic inertia, supersede outworn frameworks and repetitive rhythms unable to respond to needs. With inertia we cannot evangelize.

It is Pope John Paul II who deals with these problems; no. 36 in the Encyclical *Redemptoris Missio* is significant in referring to difficulties within the Church.

"Difficulties within the People of God are not lacking and are even the most painful ones. My predecessor, Paul VI, first of all indicated the 'lack of fervor, all the more serious when it arises from within; it is manifested in weariness, in discouragement, in self-complacency, in lack of interest, and, above all, in the lack of joy and hope' (*EN*, 80). The divisions which have existed and still exist among Christians are major obstacles the missionary sense of the Church (cf. *AG*, 6), dechristianization in Christian countries, the decrease in vocations to the apostolate, the negative testimonies of Christian faithful and communities that do not follow the model of Christ in their lives. But one of the most serious reasons for the scant interest in the missionary commitment is the mentality of indifference which is widespread, among Christians, too, unfortunately, frequently rooted in incorrect theological perspectives adhering to a religious relativism leading people to feel 'one religion is as valid as another' We may add, as the Pontiff stated, that there are also pretexts which can divert people from evangelization. The most cunning ones are clearly those claiming to find support in certain teachings of the Council (*EN*, 80).



"In this respect, I strongly recommend that theologians and professionals of the Catholic press intensify their service to the mission so as to encounter the deep meaning of their significant work along the straight path of *sentire cum Ecclesia*."

A contemporary writer,[7] commenting on the three expressions by the Pope, states the following in regard to the third, "evangelization which is new in its methods."

"Vatican II and several national episcopates have made a gift to the Church of very beautiful documents.

"With bitterness we must observe that these documents have been read by few people, and, when they have been read, they have not been so drastically effective as they should have been, for lack of pastoral projects and methodologies translating into deeds.

"*Frequently, not only projects are lacking, but even the very concept of a project*; a project is regarded as 'an annual campaign,' 'a key pastoral area,' 'a calendar for events,' and so on

"It is thus necessary to launch projects by means of which the Gospel proposal may be conveyed to all and the greatest possible number of lay people may be involved in the Church's pastoral action (as they say in Latin America, one must 'awaken the sleeping giant' that is the laity).

"Without a project and a corresponding method, *we run the risk of increasing the potential of the power plant without connecting cables taking the light to all the rooms we run the risk of building an enormous water tank without installing the tubes taking the water to all the houses.*

"This is so evident that it appears indisputable: and yet, precisely here the Church's pastoral attention is lacking. To solve this problem means to solve one of the leading pastoral problems "

I shall conclude this long reflection, before going into the criteria for pastoral programming and animation, with a word of encouragement I take from Pope John Paul II in the Encyclical *Redemptoris Missio*, no 36

"The internal and external difficulties should not make us pessimistic or inactive What counts (here as in every area of Christian life) is the confidence which comes from faith, that is, from the certainty that we are not the main actors in the mission, but Jesus Christ and his Spirit We are only co-workers."

3 *The Training of Pastoral Workers in Health*

It is difficult to carry out a new evangelization today, according to the criterion we are presenting, if workers do not possess a basic pastoral formation and if it is not periodically updated The Second Vatican Council insisted a great deal on this pastoral formation,[8] and indicated that all other aspects of formation ought to be directed towards a pastoral finality (*OT*, 4). In the Decree *Apostolicam Actuositatem*, no. 28, 29), it states that it must be multiform and complete, adapted to the various forms of apostolate (nos 16-19, 31)

"The key object will be to obtain sufficient discernment of the ways the Spirit progressively indicates to the Church in the midst of the changes of this society in radicalized, accelerated transformation It is a question of educating people in a serious theology of pastoral action encompassing all of its fields: moral, social, spiritual; to form people in the knowledge of adequate pastoral methodology and a proper set of criteria for action; to specify the terms of the Church's responsible solidarity in its action related to human society; to educate in basic work, in personal initiative, in the spirit of association, in teamwork, in openness to broader forms of solidarity" (cf. *Joint Assembly of Bishops and Priests*, Spain, Paper VII)

The *means* for this formation today are many and varied; people are formed on the basis of experience, inclusion in pastoral activities where good organization, coordination, and evaluation exists; this is a very important source of instruction One is formed by attending the classes of good teachers, courses, seminars, and study weeks For formation in Pastoral Theology for the health field to obtain the Licentiate and Doctorate, there is only one academic institution in the world, the Camillianum in Rome, run by the Camillian Fathers. We congratulate people on the fact that in many nations schools and other institutions for Pastoral Care in Health are being created, and the topic is also being included in seminaries and pastoral institutes.

We stress the need for pastoral workers to include continuing education in their plans. It must be remembered that part of such formation is to read books, journals, and other material so as to keep one's understanding and idealism alive.[9]

Someone may ask what the result is. The answer is always positive: we have come a long way, but there is still a long way to go; yet the results are enriching.

We must be careful, however, not to fall into the trap of the quantifiable. In pastoral work there are facets which have no measure.

"Pastoral action proceeds from a community of persons and tends to create a community life of faith, charity, and sharing. This has the following consequences.

1. The result of pastoral action is not measurable in quantitative terms. It is not action concluding with the production of things.

2. The characteristics proper to pastoral action call for a process of elaboration which cannot be expressed solely in juridical concepts

3. The organizational frameworks of public agencies, labor unions, and industry, for instance, are not univocally applicable to pastoral action, though all advances in human sciences concerning group dynamics, work organization, planning, and so on should be taken into account.

Pastoral action requires channels giving it greater breadth, effectiveness, and permanence We shall term such channels pastoral structures

The Church's structures are functional and instrumental for the fulfillment of her mission. For this reason they are necessary (there must be some) and contingent, for all are replaceable.

Consubstantial with the Church's pastoral structures is their instrumental, contingent, provisional character: they are never an end in themselves, but proceed from life and must serve life faithfully and renew themselves with it" (cf. *Joint Assembly of Bishops and Priests*, Spain, Paper III, 01 and 02).

IV. The Pastoral Project

After the foregoing basic reflection, in which we observed some assumptions, models, and general guidelines, in this section we must integrate four ideas: who these pastoral *workers* are, who the *beneficiaries* are, what kind of pastoral *program* we carry out, and what kind of *animation* we conduct

1 *Pastoral Workers*

The answer could be given under an enormous heading: *We are all responsible*[10]

Vatican II instructs both Bishops and priests to show the greatest concern "for the sick and dying, visiting them and comforting them in the Lord" (*PO*, 6, 8; *LG*, 38)

Canon Law (Canon 529 1) reminds the pastors of parishes of the duty to assist the sick and dying and to do so with generous charity.

The two documents of the present Pope, John Paul II, *Salvifici Doloris* and *Dolentium Hominum* (the former, on the Christian meaning of suffering and the latter, the Motu Proprio instituting the Pontifical Council for Pastoral Assistance to Health Care Workers), have started up a new movement in the pastoral care of the sick [11] This pastoral concern was also recalled by the Pope in his Apostolic Exhortation *Christifideles Laici*, nos. 53-54.

I shall now refer to two qualified types of workers at the hospital: the chaplain and the religious community

The Chaplain

— He is the pastor, the servant of the word (*EN*, 6), the qualified witness to charity; he welcomes, dialogues, respects, and serves.

— It is necessary for him to know the hospital environment well, to have a vocation for pastoral work in this area, to be competent, to prepare himself, and to devote time to planning, discovering, and assimilating

— He is not an "employee," but a witness to faith who enlightens, stimulates, coordinates, integrates, and conveys hope, experience, and life

The Religious Community

— Religious in their consecrated life have a privileged means of effective evangelization (*EN*, 69)

— Their presence is justified at the hospital only in terms of "better service" to the sick.

— Rather than managers or technical organizers, religious, in their specific jobs, ought to be a spiritual stimulus, effective and responsible co-workers alongside the chaplain, witnesses to special concern for and dedication to the sick, respectful to patients, relatives, and colleagues at work.

The first choice of a pastoral project, instead of looking at pastoral action in itself, ought to look at the pastor, the worker. Everyone gives what he or she can. Pastoral care is as good as the pastor is; evangelization is worth as much as the evangelizer; the apostolate is as good as the apostle.[12]

The author of the note we are referring to admirably explains the qualities the evangelizer should contribute so that pastoral action will be effective. I shall simply enumerate them; it is a fine decalogue.

"*The evangelizer* must be filled with God; he must be a disciple, one converted; he must have had experience of God and have received strength from above; he lives in union with God and intimacy with the Holy Spirit, associated with Him, depending upon Him; finally, he announces and works under the Word of Jesus "

2. *Beneficiaries of This Pastoral Care*

"God wants everyone to be saved and to come to the knowledge of the truth" (*1 Tm* 2:4)

"All the sick, as such, need assistance and love. But our apostolic concern must not only address itself to the sick, but also encompass health personnel and the families of patients.

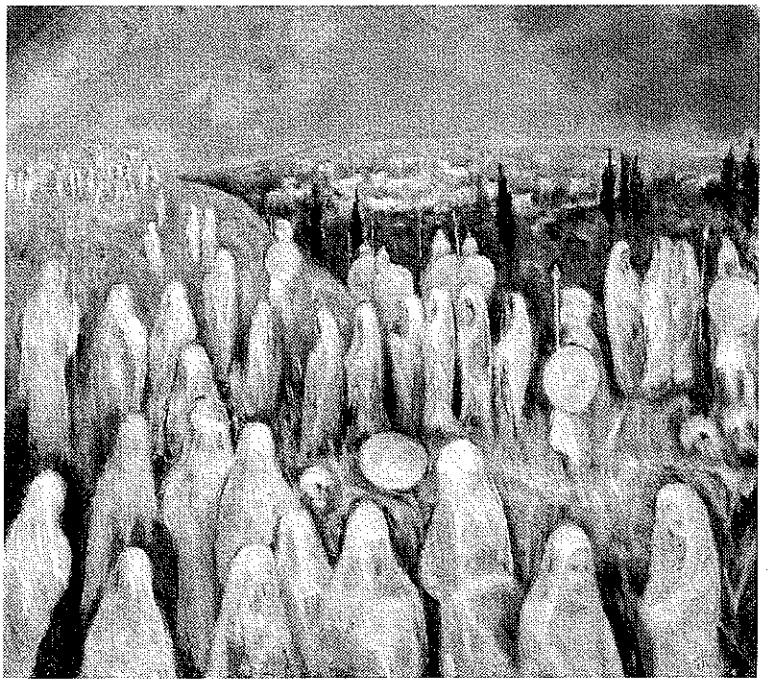
The evangelization of the world of health requires believing professionals and, of course, religious to have prior knowledge of a set of realities

a) To become aware of the health world it is our lot to live in A world with multiple facets: technical, organizational, economic, social, etc. A world which reflects and reveals many changes in the way of conceiving health today, the chances for a cure, and services by personnel.

b) A real familiarity with the world of the sick: experiences, needs, reactions, and attitudes in the face of pain, life, death, and the transcendent.

c) Knowledge of the effects of illness on the patients' environment, especially on the family, and attention to patients' needs, experiences, and alterations

d) Familiarity with health personnel: their affiliations, motivations, values, needs, and Christian dimension " [13]



Pastoral programming must take into account this general aspect (all the sick), but particularly the specific area: what patient characteristics are and what kind of health facility is involved

3 *Updated Plan for Pastoral Care in Health*

One of the signs of our world is organization To an organized, renewed hospital there should correspond programmed, renewed, and updated pastoral care. We cannot act like firemen according to what pops up; a plan is needed, an updated pastoral project for a period of one or three years.

The main elements of a pastoral plan are: animation, the animator or leader, the group, planning, and the process.

A) *Pastoral Animation*

To animate is to infuse a soul, stimulate, and create an atmosphere Animation is the art of arousing dynamics The object of animation is a certain transformation of attitudes [14]

B) *The Animator*

The future of institutions depends on groups, and these depend on the animator, since the animator has the role of a former, educator, and evangelizer.

Qualities of the animator. If animators must really be agents of change, the first step is to ask that they be animated, in an adequate state, have an open vision of the meaning of pastoral theology, and be motivated and prepared for teamwork, with a spirit of initiative and a capacity for dialogue and observation of themselves and their surroundings, and an ability to organize

Their *functions* will, of course, be those of animation: to create groups, motivate people, help to formulate objectives and take on responsibilities, and evaluate.[15]

C) *The Pastoral Team*

The team is a group of people sharing a common task. People join in a group because in that way they can better achieve a finality. It is necessary to create an awareness of belonging which comprehends a certain shared bond and kinship.

Every team or group is a dynamic reality; it follows a maturation process similar to that of the person and goes through the same stages: childhood, adolescence, maturity, and adulthood.

At the start of the formation of the pastoral team we must take into account the following factors: patience (life does not grow by pushes and shoves), a capacity for enthusiasm and hope, a certain technique (since good will is not enough), external and internal time to devote to team members, a good choice of a coordinator and an effort not to include problem people at the early stages of group formation.[16]

If animation and the animator must be factors for change and transformation, the group carries out such transformation more abundantly; it is easier to change a person integrated into a group than one who is isolated; the change effected in a team is usually longer-lasting; we also know that decisions are more readily accepted if made in a group rather than in isolation

D) *Pastoral Programming and Its Process*

"*Pastoral programming* is study, elaboration, and decision-making concerning a series of adequate pastoral efforts to make a hospital, parish, or diocese move from one state to another which is better." [17]

Having defined programming, we at once ask *how we can program* And the answer is a pastoral approach *according to objectives* [18] For we feel this process is more educational and better corresponds to the aim we are seeking. It forces us to define our options carefully and be more serious about tasks; it progressively influences the renewal of pastoral workers and obliges us to animate and coordinate more.

This organization by objectives requires us to describe the field of our pastoral work: the hospital situation and areas of influence, the dimensions of the hospital itself (patients and personnel), the kind of patient (acute, chronic, pediatric, general, etc), and religious aspects (to specify globally whether patients and their relatives are believers or not and what kind of religious practices they observe).

To Pose Objectives

Once the area of pastoral work is known, some objectives must be proposed which may be *general* (efforts at collaboration, animation, witness, and service) or *specific* (those determined each year, depending on the type of hospital and patient, with a view towards concrete proposals)

Concrete Action

The objectives are achieved through a series of activities, such as visits, catechesis, the sacraments, teaching, and meetings.

The activities to be programmed must be carefully studied; they must be realizable, interrelated, with a criterion of effectiveness, and convergent; the principles of gradualness and globalness must also be taken into account Activities must be oriented towards intermediate objectives and, of course, the final goal.[19]

In pastoral programming we must ask ourselves another question: *Who is involved?* The *pastoral coordinating team* at the hospital is involved, normally coinciding with one or more people who are officially responsible for it and are on the hospital staff.

According to the dimensions, the number will vary. There may be a chaplain and other workers (religious or lay) who bear responsibility for the religious service A *collaborating team* made up of volunteers carrying out specific tasks in an organized fashion, according to a program, may join the coordinating team.

Evaluation of Pastoral Activity

Periodic meetings are necessary at different levels: for the coordinating team in itself and

in relation to the collaborating team. These evaluation meetings enable us to program better, promote motivation and enthusiasm, and make necessary corrections.

E) *Different Models for Programming Pastoral Care in Health*

Before concluding, I would like to refer to some models published in books or journals; I shall not allude to many others which have been distributed informally

* *Pastoral de enfermos en el hospital y en la parroquia*. International Secretariat for Pastoral Care in Health St John of God Brothers General Curia, Rome, 1982, "Programación práctica de un servicio religioso," pp. 39-45

* O H Hospital Brothers Information General Curia, Rome, *Cuadernos de Pastoral Sanitaria*, No. 2 contains different models for programming: general and psychiatric hospitals, special education facilities, night shelters, the elderly, rural institutions, and pastoral care of the sick in parishes

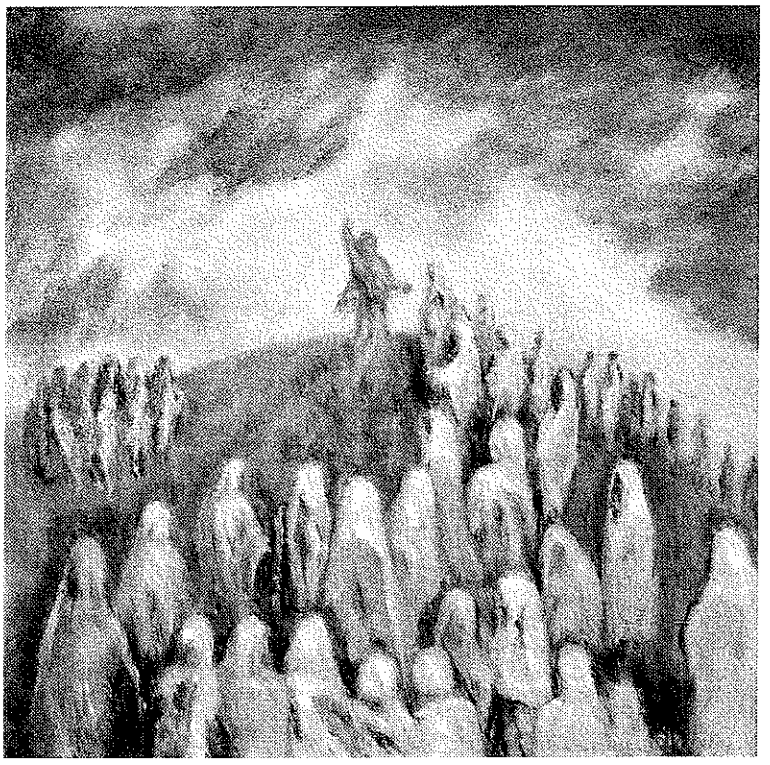
* *Boletín Informativo. San Juan de Dios (Castilla)*, No. 177 (January-February 1993) "Pastoral de la salud, un reto para servir mejor" (Programming of different religious services at hospitals).

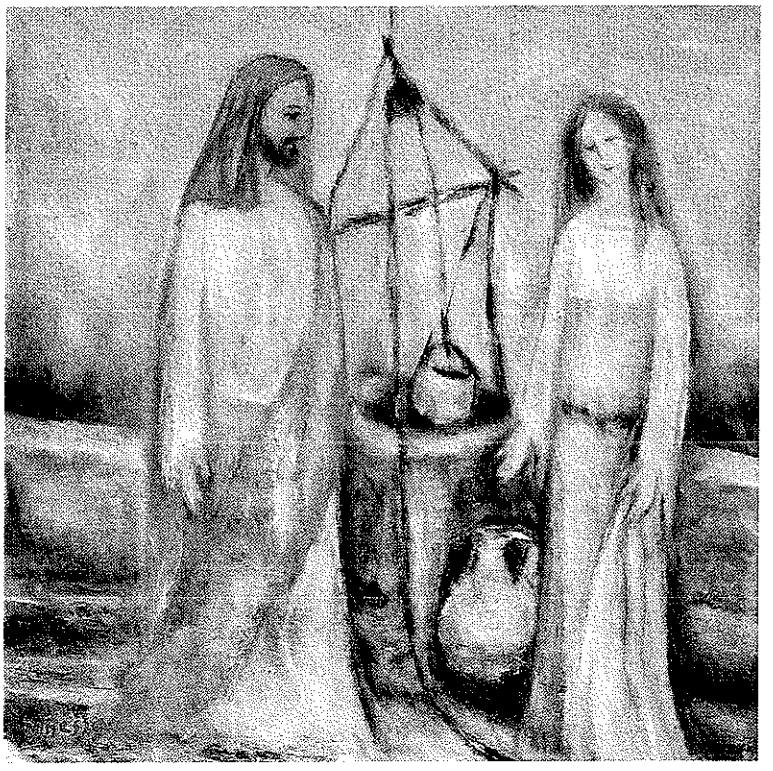
* The Journal *Labor Hospitalaria*, Nos 170 (1978) and 177 (1980), "Servicio religioso en el Hospital Infantil San Juan de Dios - Barcelona".

* The Journal *Dolentium Hominum*, no. 20 (1992), "Plan de acción del Departamento de Pastoral Sanitaria para el trienio 1990-1993 - España" (also available in the English edition of the Journal)

* Nicola De Martini, *Parrocchia 2000* (Turin: Elle Di Ci, 1993). Cf "Un esempio di programmazione," pp 319-365, where significant aspects are dealt with and there are references to different areas.

* Departamento de Pastoral Social, Boletín, no 8 (Santafé de Bogotá, September-October 1993), "Presentación del programa DEPAS 1993-1995 "





[1] José L. Redrado, *Church and Health in the World*, in *Dolentium Hominum*, no. 15 (1990) and in *Labor Hospitalaria*, no. 219 (1991).

[2] James Cassidy, "Catholic Hospitals Around the World," in *Dolentium Hominum*, no. 14 (1990), 22-23; see also Russell E. Smith, "Medical Ethics: An Offspring of the Church," in *Dolentium Hominum*, no. 15 (1990).

[3] Cf. Rude Delgado, "Presencia evangelizadora en el mundo de la salud," in *Sal Terrae* (September 1982).

[4] José L. Redrado, *Presencia cristiana en clínicas y hospitales* (Madrid: PPC, 1969).

[5] Redrado, see the article cited in note 1.

[6] *Anime e Corpi* (November-December 1992), 678.

[7] Nicola De Martini, *Parrocchia 2000* (Turin: Elle Di Ci, 1993) pp. 6-7.

[8] See my article, "Dimensión pastoral de la formación," in *Labor Hospitalaria*, no. 178 (1980), on the formation of pastoral workers in health. The reader will find numerous suggestions in this text.

[9] Fiorenzo Angelini, *Quel soffio sulla creta* (Vatican Polyglot Press, 1990). The pastoral worker in health will find in this book by Cardinal Angelini a true manual with an abundance and wealth of material. See also *Priestly Formation and the Healthcare Ministry*, a short book published by the Pontifical Council for Pastoral Assistance to Health Care Workers. The reader will find abundant criteria and justification for priestly formation in this pastoral area.

[10] Cf. The International Secretariat for Pastoral Care in Health of the St. John of God Brothers, *Pastorale degli infermi nell'ospedale e nella parrocchia* (Rome: Paoline, 1982), pp. 13-15.

[11] F. Angelini, *op. cit.*, pp. 162-182.

[12] De Martini, *op. cit.*, pp. 89-104.

[13] The International Secretariat for Pastoral Care in Health of the St. John of God Brothers, *¿Qué es la pastoral sanitaria?* (Rome: General Curia, 1980), p. 9.

[14] Maria del Sagrario Ramírez, *Dinámica de grupo y animación sociocultural* (Madrid: Marsiega, 1983).

[15] *Ibid.*, pp. 117-133. See also The Latin American Secretariat of CARITAS, *Pastoral Social* (Quito, 1990), pp. 101-112.

[16] Ramírez, *op. cit.*, p. 21.

[17] De Martini, *op. cit.*, p. 145.

[18] José L. Redrado, "Pastoral en los centros hospitalarios," in *Labor Hospitalaria*, no. 185 (1982).

[19] De Martini, *op. cit.*, pp. 148-150. See also M. Cabello, E. Espinosa and J. Gómez, *Manual de planificación pastoral* (Caracas: Paulinas, 1987) and the volume written in collaboration *De masa a pueblo de Dios* (Madrid: PPC, 1982).

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— Motu Proprio *Dolentium Hominum* (February 11, 1985), the decree instituting the Pontifical Council for Pastoral Assistance to Health Care Workers.

— *Letter* to Cardinal Angelini (May 13, 1992) instituting the World Day of the Sick, to be celebrated annually on February 11th, commemoration of Our Lady of Lourdes

— Encyclical *Redemptoris Missio* (December 7, 1990), on the permanent validity of the missionary mandate

The Pontifical Council for Pastoral Assistance to Health Care Workers

— The Journal *Dolentium Hominum*, in English, Spanish, French, and Italian editions

— Several books available in English, Spanish, French, and Italian:

- *Religious in the World of Suffering and Health Care*
- *The Laity in the World of Suffering and Health Care*
- *Priestly Formation for the Pastoral Care of the Family*
- *The World Day of the Sick*

Video production: *John Paul II and the Sick. The Value of Suffering*, in English, Spanish, French, and Italian.

The SI. John of God Brothers

International Secretariat for Pastoral Care in Health:

- *What Is Pastoral Care of the Sick?* (Rome, 1980), available in English, Spanish, Italian, and Portuguese.
- *The Pastoral Care of the Sick at the Hospital and in the Parish* (Rome, 1982), available in English, Spanish, Italian, and Portuguese.
- *Dimensión apostólica de la Orden Hospitalaria de San Juan de Dios* (Rome, 1982)
- *Cuadernos de Pastoral Sanitaria*, nos. 1-3.

Selare

- The Journal *Selare*.
- A collection on pastoral subjects
- A correspondence course to train pastoral workers in health

Interprovincial Secretariat in Spain

- Correspondence course to train pastoral workers, including short books for students

Animation, Programming, and Groups

Aitlano Alaiz, *El animador de grupo* (Madrid: Paulinas, 1984)

In collaboration, *De masa a pueblo de Dios* (Madrid: PPC, 1982)

Beauchamp, Graveline, Quiviger, *Cómo animar un grupo* (Santander: Sal Terrae, 1985)

Jesús Andrés Vela, *Dinámica psicológica y eclesial de los grupos apostólicos* (Buenos Aires: Guadalupe, 1971)

Maite Melendo, *Comunicación e integración personal* (Santander: Sal Terrae, 1985)

In collaboration, *Manual de Planificación Pastoral* (Caracas: Paulinas, 1987)

María del Sagrario Ramírez, *Dinámica de grupo y animación sociocultural* (Madrid: Marsiega, 1983)

Latin American Secretariat of CARITAS, *Pastoral Social* (Quito, 1990)

Nicola de Martini, *Parrocchia 2000* (Turin: Elle Di Ci, 1993)

In collaboration, *L'animatore nel gruppo giovanile* (Turin: Elle Di Ci, 1992)

In collaboration, *Guida dell'animatore cristiano* (Bologna: EDB, 1990), nos. 17-19

Mario Comiglio, *Abilitare l'animazione* (Turin: Elle Di Ci, 1991)

Varied Topics Concerning Pastoral Care in Health

Fiorenzo Angelini, *Quel soffio sulla creta* (Vatican Polyglot Press, 1990)

José I. Redrado, *Presencia cristiana en clínicas y hospitales* (Madrid: PPC, 1969)

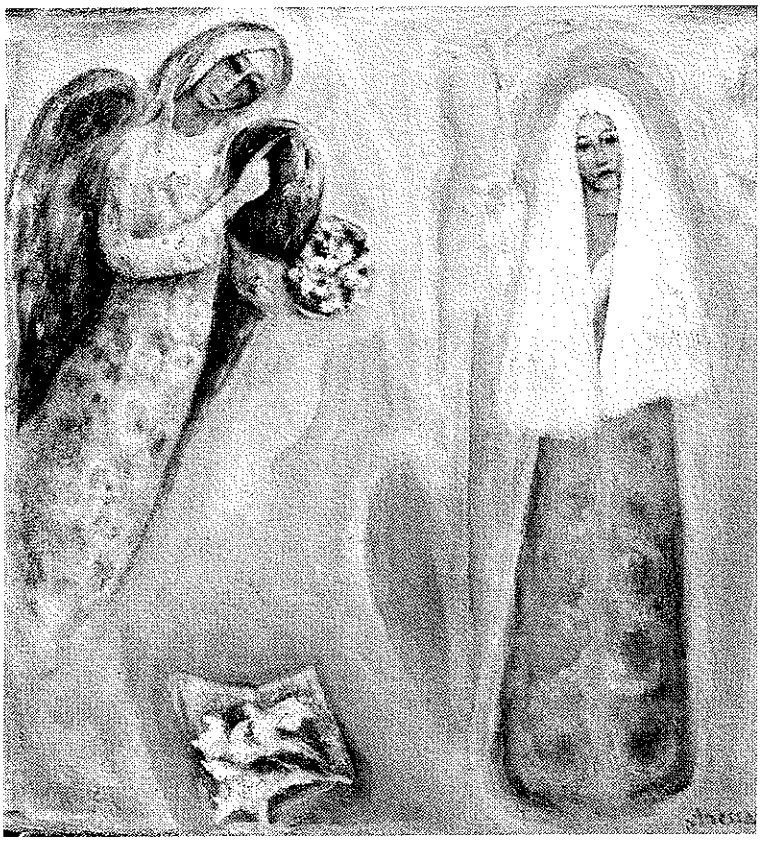
Spanish National Secretariat for Pastoral Care in Health:

- *La asistencia religiosa en el hospital* (Madrid: Edice, 1987)
- *La Iglesia en el mundo de la salud* (Madrid: Edice, 1982)

In collaboration, *La Iglesia y los hospitales* (Barcelona: Ariel, 1969)

In collaboration, *Los religiosos al servicio de los enfermos* (Madrid: Institute for the Theology of the Religious Life, 1982)

Illard, *En el mumdo sin ser del mundo* (Santander: Sal Terrae, 1982)



Pastoral Bureau for the Sick in Brussels, *The Christian Community and the Sick* (Matova 1980)

A Perulan and P. Saavedra, *Evangelizar hoy a los enfermos* (Bogotá: Selare No 3, 1980)

In collaboration, *Los religiosos ante la actual situación en España* (Madrid: Institute for the Theology of Religious Life, 1983)

In collaboration, *Evangelización y hombre de hoy* (Madrid: Edice, 1986)

Camillian Editions

— The *World of Health* Collection:

Pangrazzi, *Creatività pastorale a servizio del malato* and *Il lutto un viaggio dentro la vita*

Casera, *L'assistente religioso nel mondo della sanità*

Buckman *Cosa dire? Dialogo con il malato grave*

In collaboration, *Presenza nella sofferenza* and *Mosaico della misericordia*

Also of interest for pastoral workers are three other *collections* among the Camillian Editions:

- The *Experiences* Collection (*Esperienze*)
- The *Pathways of Hope* Collection (*Sentieri della speranza*)
- The *Healthcare Workers* Collection (*Operatori Sanitari*)

Journals

Dolentium Hominum (English, Spanish, French, and Italian editions) The Pontifical Council for Pastoral Assistance to Health Care Workers, Vatican City

Labor Hospitalaria (Spanish) St John of God Brothers, Ctra. Esplugas s/n, 08034 Barcelona, Spain

Selare (Spanish), Carrera 8a, no. 17-44 Sur, Apartado aéreo 8669, Santafé de Bogotá D.C., Colombia.

Camillianum (Italian), Piazza della Maddalena, 53, 00186 Rome

Anime e Corpi (Italian), Località Canonica 3, 21020 Brezzo di Bedero, Varese, Italy.

Medicina e Morale (Italian), Facoltà di Medicina, Largo Francesco Vito, 00168 Rome.

MOSCOW

Laying of the Foundation Stone

On July 25, 1993 in Moscow there took place the laying of the foundation stone and the blessing of the start of construction work at the Blagocenter Children's Hospital for Rehabilitation after an agreement was reached in this regard between the Government of Moscow and the Apostolic Administration of the Russian capital

The initiative for building this healthcare institution and all it involves was taken by the Pontifical Council for Pastoral Assistance to Health Care Workers, which followed the long and laborious negotiations The costs of the new hospital and its operation have been covered by the generous charity of friendly benefactors who have grasped the significance and value of a project for providing health care to children. The new Hospital is being created in one of the most heavily populated areas of the Russian metropolis.

At the ceremony the Pontifical Council for Pastoral Assistance to Health Care Workers was represented by His Eminence Fiorenzo Cardinal Angelini, President; Rev. José L Redrado, Secretary; Professor Franco Splendori, M.D.; and Mr Luciano Fiordeponti; the Papal Representative in Moscow, Apostolic Nuncio Francesco Colasuonno, took part as well, along with the *Apostolic Administrator of Moscow*, Archbishop Tadeusz Kondrusiewicz; the *congregation of women religious who will provide care at the Hospital* was represented by Mother M. Maurizia Biancucci, Superior General of the Benedictine Sisters for Reparation to the Holy Face of Our Lord Jesus Christ, and M. Quirina Pelella; *the government in Moscow* was represented by the Minister of Health, Parliamentary Deputy Anatoly Nikolaevich, and Deputy Prefect of Moscow Sergei I Khoudyakov; those responsible for construction work also attended.

Cardinal Angelini had spoken with the Minister of Health the day he arrived in Moscow (July 23), and on that occasion the representative of the Government of the Russian Republic had manifested his appreciation for the Catholic Church's sensitivity to the problems of health policy and care. The Minister of Health and his Advisor, Dr. Dmitrij Dechaev, were also invited to take part in the next Conference organized at the Vatican by the Pontifical Council for Pastoral Assistance to Health Care Workers, to be devoted to the topic "The Child Is the Future of Society."

The ceremony of blessing and inaugurating construction work was divided into four parts: the opening recitation of the Our Father; statements by Archbishop Kondrusiewicz and Cardinal Angelini; depositing in the ground a commemorative document; and words by the Health Minister of the Russian Republic and the Deputy Prefect of Moscow.

In his statement *Archbishop Kondrusiewicz* sincerely thanked Cardinal Angelini and all his co-workers for their tenacity in carrying forward the idea of constructing a new Hospital which, in rising over the ruins of a pre-existing building, symbolized the rebirth of the Church in Russia after seventy years of persecution and marginalization

Cardinal Angelini thanked the government authorities, above all, for having favored the initiative and conveyed his sincere gratitude to the Papal Representative, Apostolic Nuncio Francesco Colasuonno, and the Apostolic Administrator of Moscow for their wholehearted cooperation, a gratitude he also expressed on behalf of the religious congregation hoping to work at the new Hospital. The Cardinal then manifested his willingness to offer a service seeking to contribute to the rebirth of the Russian people through a testimony of love aimed at the weakest and neediest, regardless of their race, language, or political and religious beliefs; he also confirmed his intention of working together with his brothers in the Orthodox Church.

The Cardinal said he was happy to see the creation of an institution serving children, who represented the future of our society, and stressed the coincidence that precisely this year the Eighth International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers was devoted to that subject Finally, he recalled and blessed all the construction employees and workers, that they might be aware of contributing to the creation of an instrument of comfort and relief for children, of a place of prayer and suffering. Cardinal Angelini concluded by recalling the Pope's concern for all the suffering, and for children in particular, and his joy over this new initiative.

The signing of the document recording the ceremony then took place, and a copy of it, with a medal depicting the Holy Face of Our Lord and the Servant of God Abbot Ildebrando Gregori, were sealed in a container introduced within a column of the hospital under construction. The Church and civil officials then proceeded to wall in the little container.

When this ceremony was over, Health Minister Anatoly Nikolaevich spoke. Addressing Cardinal Angelini, in particular, he

said he was happy that all obstacles had been overcome so as to arrive at the creation of this hospital facility He then expressed his hopes for the greatest possible increase of the Church's service in care for children.

Finally, Moscow's Deputy Prefect Koudyakov spoke, dwelling upon the significance of this building arising in one of the most populous areas in Moscow and voicing the hope that the new Hospital would become the nucleus of a growing activity of service.

The new hospital building for child rehabilitation in Moscow will be completed and opened for care in twelve months.

PARIS

The Site of Various Meetings

The Seventh Mediterranean Medicine Colloquium, organized by the Health Sciences Institute of Paris, took place in Nice, May 14-15, 1993, and was devoted to "La Fonction de Doyen de la Faculté de Médecine" The Pontifical Council for Pastoral Assistance to Health Care Workers was represented by Rev. Jean-Marie Musivi Mpendawatu, a member of the official staff

The first meeting of the International Bioethics Committee, recently instituted by UNESCO, took place at UNESCO headquarters in Paris, September 15-16, 1993. Over fifty members of the IBC from all continents, including Rev Jean-Marie Musivi Mpendawatu from our Office, attended as observers and representatives of institutes, committees, associations, and organisms concerned with the problems of bioethics On the agenda were the study and definition of questions to be dealt with, the methodology to govern work, the spirit of the IBC, and the calendar for future meetings until the end of 1996.

The Twenty-First UNESCO Conference was held in Paris The Delegation of the Holy See, headed by the Apostolic Nuncio in France, the Most Rev Lorenzo Antonetti, was made up of six members and five experts; one of the latter was Rev Jean-Marie Musivi Mpendawatu, who attended the sessions of the Social Commission, which was scheduled to deal with the ethical problems concerning the "human genome project."

Budapest

Bioethics Conference

Over 300 people, largely physicians, took part in the International Conference held in Budapest, June 16-19, 1993. The Hungarian doctors were the most numerous contingent, but others attended from Great Britain, Germany, Slovakia, the Czech Republic, Romania, and Italy.

The meeting transpired in an ecumenical atmosphere, with the participation of many Protestants Dr. Gyula Gaizler, President of the Bioethics Center of Hungary, was the main organizer of this Conference

As the official representative of the Pontifical Council for Pastoral Assistance to Health Care Workers, Monsignor James Cassidy spoke at the beginning of the meeting

The stimulating discussions which unfolded during the Conference dealt with the implications for participants of Catholic moral teaching, even though the Hungarian Protestants constituted a majority

COLOGNE (Germany)

Conference of Catholic International Organizations

Thirty Ecclesiastical Advisors from different countries took part in the Conference of Catholic International Organizations, October 10-16, 1992. The core meeting (October 10-11) focused on the role of the Ecclesiastical Advisors in relation to Catholic organizations, on the qualities demanded of these chaplains, and on their training

A report on this meeting was presented to the General Assembly The Ecclesiastical Advisors insisted on the responsibilities of chaplains to organizations and the necessity of training them for their tasks, both locally and nationally.

Monsignor James Cassidy attended in his capacity as Advisor to the International Federation of Catholic Medical Associations

TROINA (Italy)

Cardinal Angelini took part in the Meeting on "Longevity and Society" organized by Holy Mary Oasis in Troina, Sicily. He was accompanied by Professor

Franco Splendori, a Consultor to the Pontifical Council On September 16 Cardinal Angelini delivered a talk on "The World of the Elderly," which appears in this issue of our journal.

PRAGUE

Symposium of European Bishops' Conferences

"Freedom and Solidarity" was the topic of the Symposium held in Prague, September 7-12, 1993.

The subject was dealt with in an excellent spirit of dialogue among the prelates representing the European Bishops' Conferences and other Church organisms The Pontifical Council was represented by Rev Jean-Pierre Schaller, one of our Consultors.

BRUSSELS

Communication and Pharmaceuticals

The Health Sciences Institute organized a European Colloquium on this topic, October 15-16, 1993. Dr. Jean Dréano, Member of the French National Academy and formerly a Member of our Pontifical Council, represented our Office.

ROME

Course on Pastoral Care in Health

The St. John of God Brothers held an International Meeting on "Pastoral Care in Health" aimed at health professionals in the context of the facilities where they work.

Cardinal Angelini was among the speakers, opening the sessions with a talk entitled "What Does the Church Expect from Us as Consecrated Persons in Hospital Care?" Fr Redrado also guided a day-long session with a paper on "The Programming and Direction of Pastoral Care in the Health Field." Both talks appear in this issue of our journal.

VATICAN CITY

Eighth International Conference: "The Child Is the Future of Society"

In the Paul VI Audience Hall the Eighth International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers (entitled "The Child Is the Future of Society") took place, November 18-20, 1993

Several Nobel Prize winners (Rita Levi Montalcini, Joseph E Murray, M. Oscar Arias) took part, along with numerous scientists, researchers, pedagogues, pediatricians, jurists, sociologists, moral theologians, and representatives of the leading international organizations engaged in protecting children, including the General Directors of UNICEF and the World Health Organization The topics and problems dealt with were those considered by the *International Convention on Children's Rights*, approved by the United Nations General Assembly on November 20, 1989 and already signed by 135 states, including the Holy See, and by the *World Declaration* and the *Plan for Action* approved by the World Summit on Children, held in September 1990, in which the Holy See also took part.

The Conference thus made a contribution to increasing awareness and understanding so that the goals for the benefit of children programmed for this decade might truly be reached Among the most urgent ones are the *elimination* of poliomyelitis, tetanus in the newborn, and the diseases caused by vitamin A and iodine deficiencies; to *halve* infant mortality due to gastrointestinal illnesses; to *reduce* the rate of maternal mortality and serious malnutrition by a third; to *guarantee* potable water and sanitation systems for all families; and to *initiate* an educational program with the fight against illiteracy.

The Conference was structured by an interdisciplinary approach, with papers and communications concerning prenatal diagnosis, birth, perinatal and childhood diseases, the acceptance of children, their psychophysical development, and the needs connected with their growth and social adjustment, with special attention to their family background

The criterion behind the Conference remains the assumption that only by recovering an integral conception of the advancement and defense of life and its quality can we shake consciences and also make it possible for needed resources to reach their target and solve children's problems

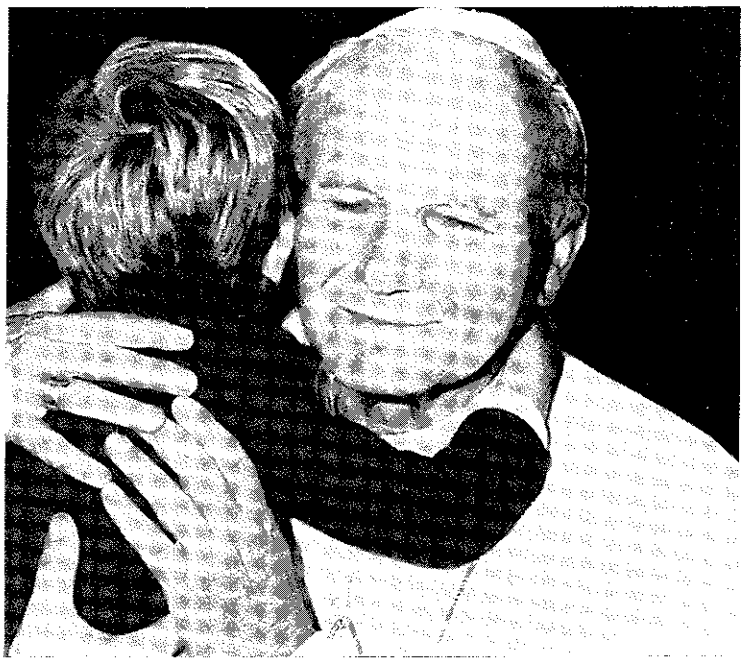
Over 8,000 people took part in the Conference, representing 106 nations. Several health ministers, numerous ambassadors, and many government officials attended.

The Address by the Holy Father, John Paul II, in Paul VI Hall concluded this major event.

The Conference *Proceedings* will be published in four languages in our journal *Dolentium Hominum*, no 25 (1/1994).

The Pontifical Council for Pastoral Assistance
to Health Care Workers

PRESENTS



JOHN PAUL II AND THE SICK

The Value of Suffering

Produced by
VATICAN TELEVISION CENTER

The Pope in the midst of the sick and for the sick. A document of the Magisterium and Ministry of John Paul II in the world of human suffering.
John Paul II, who has personally experienced the weight of illness, represents an exceptional witness to the deepest meaning of suffering. A gallery of suggestive, touching images of the presence of the Church alongside the sick. An up-to-date document on the message of solidarity and Christian charity. An example to be admired and imitated.

JOURNAL OF THE PONTIFICAL COUNCIL FOR PASTORAL ASSISTANCE TO HEALTH CARE WORKERS

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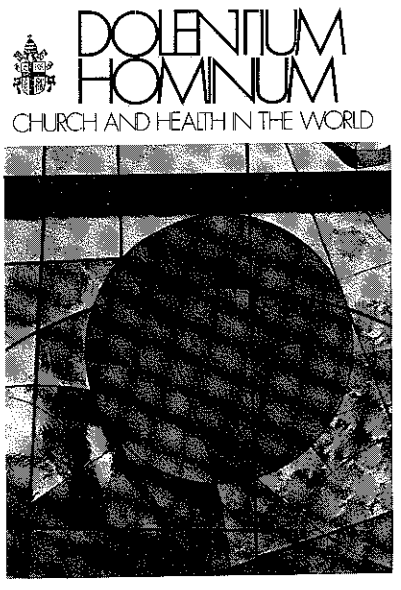

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In the next issue

The *Proceedings* of our Eighth International Conference, "The Child Is the Future of Society," will be published. The Conference was organized by our Pontifical Council and took place at Paul VI Auditorium in Vatican City, November 18-20, 1993. Nonsubscribers to our journal may obtain the *Proceedings* by sending a check for $80 made out to the Pontifical Council for Pastoral Assistance to Health Care Workers, at Via della Conciliazione 3, 00193 Rome, Italy.

We advise subscribers that we shall assume their intention to renew their subscriptions for 1994 unless they notify us to the contrary