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Editorial and
Business Offices:
Vatican City
Telephone: 6988-3138,
6988-4720, 6988-4799,
Telefax: 6988-3139
Telex: 2031 SANITPC VA

In copertina:
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organized by the Pontifical Council for Pastoral Assistance to Health Care Workers

Vade et Tu Fac Similiter:
From Hippocrates To the Good Samaritan

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GREETING ADDRESSED TO THE HOLY FATHER
BY HIS EMINENCE CARDINAL FIORENZO ANGELINI

A Man Went Down To Jericho

Holy Father, once again you have wanted to take part in the conclusion to the annual international conference organized by the Pontifical Council for Health Care Workers. This is the tenth such international conference.

Your contributions, Holy Father, to the subjects of great relevance discussed by these conferences constitute vital points of reference for doctrine and practice in the vast, intricate and ever more complicated field of the relationship between science and its practical application, and between biomedicine in its widest forms of expression and moral law.

We thank you greatly for your fatherly participation, a participation which is another example of the extraordinary and providential attention paid by you to the very serious questions and problems which now concern the world of health policy and care.

On the tenth anniversary of this Council, whose establishment you sought in order to demonstrate that the solicitude of the Church for the suffering and the sick, and for health care workers at all levels of responsibility, is an integral part of her mission, this tenth international conference has addressed itself to the subject: *"Vade et Tu Fac Similiter: From Hippocrates to the Good Samaritan."*

Allow me, Holy Father, to observe that your Magisterium and ministry are the living, courageous, and most authoritative realization of this task. As you yourself stressed at the general assembly of the United Nations last October: "There is nothing which is genuinely human which does not find an echo in the Christian heart."

Your forceful defense of fundamental human rights—and above all else the right to life, its sacredness, inviolability, and dignity—and the constant preaching of the gospel of suffering have presented the world with the highest expression of evangelical and rational values. Indeed, if it is true, as *Evangelium Vitae* affirms, that "in life there is certainly a sacred and religious value, in no way does this value concern only believers: if it is a value which every human being can understand, in the light of reason as well, and which therefore necessarily concerns everybody" (no. 101).

For you, Holy Father, the road which goes down from Jerusalem to Jericho is the road which traverses our whole planet: a road which you have gone down and continue to walk along tirelessly in order to meet the innumerable victims of the violence of our times and our days.

Just as the illuminated medieval scribe transcribed the Hippocratic oath in the form of a cross, so you have made the advancement and the defense of life the meeting point for the Gospels, for knowledge, and for belief.

Thank you, Holy Father, for this secure and strong guidance which gives us the hopeful intelligence and the exemplary courage to fight a difficult—because decisive—battle.

We have already begun our preparations for the next international conference, which will be held in 1996. The general subject of the conference will be:

"In the Image and Likeness of God:
Always? The Disturbances of the Human Mind."

The subject is of extraordinary relevance and directly concerns about a billion people in the world. We want, Holy Father, to go on being very willing to help at all times, to be authentic Samaritans for everybody, but especially for all those—without distinction—who suffer in the body, in the spirit, and in the mind.

Thank you, Holy Father, for your long-awaited and enlightening words.

ADDRESS BY THE HOLY FATHER

Be the Good Samaritans of Modern Times

1. I am happy to be addressing all of you, very dear Brothers and Sisters, during this International Conference, which has now become a traditional appointment each year bringing together so many generous people marked by enthusiasm and fidelity who are involved in the world of health policy and care.

This year, in addition, we are recalling a special anniversary: ten years have in fact passed since the Pontifical Council for Pastoral Assistance to Health Care Workers was instituted. The success of the Conferences held until now is tangible proof of the fruits ripened through the tireless and fervent activity conducted by this Council, whose aim is to "disseminate, explain, and defend the teachings of the Church in the field of health and foster their introduction into the practice of health care" (Apostolic Letter, Dolentium Hominum, *no. 6).*

I affectionately greet Cardinal Fiorenzo Angelini and thank him for the kind words with which he has conveyed the sentiments of all those present. I reiterate my deepest appreciation of those responsible for the Pontifical Council for Pastoral Assistance to Health Care Workers, who, with assiduous and constant dedication have promoted and organized this meeting. I also respectfully address the distinguished scientists, researchers, scholars, and experts on problems in medicine, the biomedical sciences, and morals who have offered this encounter for study and reflection the valuable contribution of their competence and experience. Finally, I extend my cordial welcome to all present.

In your persons I see and greet all the health workers who, everywhere in the world, as servants and guardians of life, witness to the Church's presence alongside sick and suffering people.

2. This year you have chosen to conduct your reflection in the light of the Gospel exhortation: "Vade et Fac Tu Similiter: *From Hippocrates to the Good Samaritan." In this twofold allusion the whole history of medicine may be well summarized. As, indeed, Pope Pius XII, of venerable memory, recalled, "The writings of Hippocrates, beyond all doubt, contain one of the noblest expressions of professional conscience, which particularly imposes respect for life and dedication to the sick" (Address to Those Attending the Fourteenth International Congress on the History of Medicine, September 17, 1954:* Discorsi e Radiomessaggi *XIV [1953-1954], 148). The Gospel page on the Good Samaritan enriches the Hippocratic heritage with the transcendent vision of human life, which is a gift of God and is called to share in eternal communion with Him.*

With rigorous attention to the serious and urgent problems challenging medical research and science in our time, during the sessions held in these days you have journeyed anew along the road traveled by health care throughout history, identifying in the encounter between Hippocratic humanism and Christian humanism a decisive factor for progress towards a civilization increasingly worthy of this name. Furthermore, the scientific contributions presented by scholars and experts from all over the world have demonstrated that, in attention to those suffering and commitment to quality of life worthy of the person, an anthropological vision is shaped in which it is possible for people of different cultures to find a point of encounter. This is confirmed by the personal and social experiences of so many "Good Samaritans" of modern times, among whom you have appropriately wished to recall people such as Henry Dunant,

Florence Nightingale, Albert Schweitzer, Janusz Korczak, Ildebrando Gregori, Raoul Follereau, and Marcello Candia. "Whoever embarks on the little boat of defense of life," Albert Schweitzer wrote, "is not a shipwrecked person cast adrift, but a bold traveler who knows where to go and firmly holds the rudder in the right direction" (La civilisation et l'éthique, *63-64).*

3. From Hippocrates to the Good Samaritan, from conscience guided by reason to reason enlightened by faith, the announcement of the Gospel of life must be single; indeed, its advancement and defense "are not the monopoly of anyone, but the responsibility of all" (Encyclical Evangelium Vitae, *no. 91). And it is certainly a providential sign of the times that faith in Christ's message is today called to support and strengthen the rational foundation for the common duty of serving life in all phases of human existence. It is, indeed, a task which is at once human and Christian, in such a way that "only unified cooperation among those believing in the value of life can avert a defeat for civilization with unforeseeable consequences"* (ibid.)

The Good Samaritan of the Gospel parable challenges every human conscience aspiring to truth and attentive to the future destiny of mankind. The long road traveled by health care, however, could not be accounted for if it had some purpose other than the safeguarding and recovery of health; in reality, health care, because it is rooted in respect for life and for the dignity of the human person, is also a school for giving value to suffering and the service it calls for. Therefore, the parable of the Good Samaritan pertains to both the Gospel of life and the Gospel of suffering: "And here we touch one of the key points of all Christian anthropology. Man cannot find himself fully except through a sincere gift of himself. The Good Samaritan is the man capable of precisely such a gift of himself" (Apostolic Letter Salvifici Doloris, *no. 28).*

For these reasons I am happy to express to those responsible for the Council for Pastoral Assistance to Health Care Workers my deep satisfaction over their having drafted and published the first Charter for Health Care Workers, *whose indications, open to contributions by all men of good will, represent a happy alliance between Hippocratic ethics and Christian morals. It is, in fact, a synthesis through which "reflection and dialogue – among believers and nonbelievers and also among the believers of different religions – on ethical problems, including fundamental ones regarding man's life, are fostered" (Encyclical* Evangelium Vitae, *no. 27).*

4. The unified and constructive path of science and faith desired by the Second Vatican Council (cf. Message to Men of Science, *December 8, 1965) tends to affirm basic human rights centering on the advancement and defense of life and its dignity. Faith stimulates, encourages, and supports this convergence, which has revealed itself to be favorable to the achievements of reason, for there is nothing genuinely human which is not echoed in the heart of Christians.*

The field of health policy and care, in the varied spheres of health education, prevention, diagnosis, therapy, and rehabilitation, offers numberless proofs of the concrete possibility of an association between reason and faith, *to construct, in freedom and full respect for the human person, the civilization of life, which, to be truly such, must also be a civilization of love.*

5. In the building of such a civilization, the Good Samaritan, in whom the love of the Son of God is mirrored, is a model for the duties and tasks of health care workers. This model reaffirms, dearest Brothers and Sisters engaged in health care and pastoral attention to the sick, that your service is first of all a mission, rather than a profession, sustained by a growing awareness of solidarity existing among human beings. This awareness is strengthened and encouraged by faith, to which I exhort you to offer generous witness, as heralds of trust and hope in man, called by God to fulfill himself in self-giving.

With these wishes, for all of you and your service to the sick I invoke the protection of the Most Blessed Virgin, to whom I entrust the plea for salvation and comfort arising from suffering humanity. May Mary, the Mother of the Divine Samaritan of souls and bodies, accompany all your meritorious activities, impressing upon them the maternal characteristics of loving receptiveness and inexhaustible generosity. May you also be accompanied by my Apostolic Blessing, which I cordially bestow upon all of you present here, upon your associates, and upon those you assist in your daily work.

The Hippocratic Oath

I swear by Apollo the Physician, Aesculapios, Hygeia, and Pancea, and call all the gods and goddesses as witnesses that I will integrally observe this oath of mine with vigor and intelligence.

I will regard the Teacher who taught me this art as a father, and in a grateful spirit I will give him what he needs to live and what he may require, and I will consider his sons as my own brothers; and if they wish to learn this art, I will teach them with no compensation or contract; I will share my lessons and presentations and all that concerns the medical discipline with my sons and the sons of my preceptors and with those who have declared themselves in writing to be my disciples and have sworn an oath, but not with anyone else aside from these.

As regards the care of the sick, I will prescribe the most appropriate regimen, according to my judgment and knowledge and will defend the sick from all harm and disturbance.

Neither will any request avail to induce me to administer poison to anyone, nor will I ever so advise.

Similarly, I will not operate on women for the purpose of impeding conception and procuring abortion.

And, in truth, I will keep my life upright and my art immaculate.

Nor will I perform operations to remove stones from those suffering therefrom, but will let surgeons expert in this art do so.

I will enter any house solely to bring aid to the sick and will refrain from every unjust action and immorality, as well as from all impure contact.

And, in practicing my profession, I will keep silent, unless given permission, about all that I see and hear in the common life of men, even if independent of the medical art.

If I unalterably keep faith with this oath and am able to observe it loyally, may I be granted every satisfaction in life and in the art, and may I always enjoy a well-deserved good reputation among men.

But if I should not keep my oath or should swear falsely, may just the opposite befall me.

The Parable of the Good Samaritan *(Luke 10:30-37)*

(30) “A man who was on his way down from Jerusalem to Jericho fell in with robbers who stripped him and beat him, and went off leaving him half dead.

(31) And a priest, who chanced to be going down by the same road, saw him there and passed by on the other side of the road. (32) And a Levite who came there saw him, and passed by on the other side.

(33) But a certain Samaritan, who was on his travels, saw him and took pity at the sight; (34) he went up to him and bound up his wounds, pouring oil and wine into them, and then mounted him upon his beast and brought him to an inn, where he took care of him.

(35) And the next day he took out two silver pieces, which he gave to the innkeeper and said, “Take care of him, and on my way home I will give you whatever else is owing to you for your pains”.

(36) Which of these, do you think, proved himself a neighbor to the man who had fallen in with robbers?

(37) And he said, “He that showed mercy on him”. Then Jesus said, “Go your way, and do likewise.”

Read by BENEDETTO NARDACCI
The Vatican Television Center

FIORENZO ANGELINI

The Meaning of a Historical Trajectory

"Go on your way, and do likewise." From Hippocrates to the Good Samaritan.

The subject "From Hippocrates to the Good Samaritan" does not express a general juxtaposition. In the same way it does not amount to a contrived or artificial tandem. Look at the back of the program of this international conference and you will see why this is so. In the past this fact was understood. But today, in many quarters, it seems that there is a desire that it should be forgotten. Nobody had ever sought to put a cross or a Christian symbol on the frontispiece of works by Aristotle—works which even such an outstanding theologian as Thomas Aquinas adjudged precursors of Christian thought. Nor had anyone ever sought to do likewise with the works of Cicero, a figure whom Tertullian called *"anima naturaliter christiana."* But such an act was performed by an enlightened Medieval scribe when he transcribed the Hippocratic oath in Greek in the form of a cross. The manuscript is kept in the Vatican library. The inference is obvious: he who read the Hippocratic passage with care perceived in it the teaching of Christ.

There is an undisputed continuity between the content of the Hippocratic oath and the content of Christian morality. This continuity lies in a shared commitment to promote and defend life from its conception to its natural ending. This is a continuity which is emphatically observed by the Holy Father John Paul II, among many others. In the encyclical *Evangelium Vitae* His Holiness refers to the "ancient and ever relevant Oath of Hippocrates, according to which every medical doctor is called upon to be committed to absolute respect for human life and its sacredness."

The Hippocratic Oath, indeed, has four general features, and these are:

* a profound respect for nature in general;

* a unified and integral conception of the human being;

* a rigid and strict relationship between personal ethics and professional ethics;

* a mainly participatory vision of the exercise of the art of medicine.

There is, therefore, an evident precursory element within the Hippocratic Oath which leads on to the Christian vision of life—a vision which adheres to (and enriches) all of these four features of the oath. But it is, above all, in the full and total defense of life that the position of this great Greek doctor and physician created a receptivity to the acceptance of the Christian belief that life is participation in the life itself of God projected into eternity. And it is here that there is a crucial point at which the thought of Hippocrates and Christian thought coincide—in the exclusion of any possibility of discrimination in relation to the notion of life. Hippocrates sees the promotion and the defense of life as a criterion and guide for the practice of his profession and as a measure by which to judge the honesty and correctness of the medical doctor. He knew full well that the acceptance of possible distinctions which involved exceptions to this principle would mean that this principle would become fragile and vulnerable. And he is so convinced of this fact that his oath draws near to a religious view of life. Indeed at the beginning of the oath the physician from Kos refers to the divinities of the Greek pantheon and at its close he seems to echo these initial words when he wishes every ill to befall him if he should ever diverge from his oath.

There are two other elements in Hippocratic ethics which have an almost Christian aspect. They are, in the first place, the need for the medical doctor in the practice of his profession to be at the service of the sick person and not to act in his own calculated and selfish interest. And he is so convinced of this that he sees a non-utilitarian reward as the prize for the correct exercise of his profession. Indeed, the person who is called to the bed of those who suffer well knows—as the Schola Salernitana of medical thought makes clear—that the doctor is forgotten about when the illness or ailment has passed away and that as a

result there is a temptation to present the bill for professional services when the patient is most in the grip of his infirmity. Here we can see the contemporary relevance of a Christian defense of the Hippocratic Oath, especially in an age such as this, when we find that side by side with great advances in the realm of science and technology we are threatened by their being placed at the service of wrongful goals and by their employment as instruments in the achievement of wrongful ends.

A careful analysis of the Hippocratic Oath enables us to come to a simple conclusion: few professional categories can so agree upon the essential principles of their activity as those who are engaged in service to health—I am referring here, of course, to health care workers. Through an identification of the Christian view of the world with the vertical and horizontal beams of a cross, and its encounter/comparison with the non-Christian view or views, we might imagine service to health—and thus to life—as the exact point at which the two beams meet.

It is certainly true that in this field as well the very newness of Christianity is expressed in the doctrine and practice of the attribution of value to suffering when that suffering, notwithstanding the efforts of science and of every other means, cannot be removed. But in truth few truths are so rational as the attribution of value to suffering—something which draws upon all the resources of man and enables him to reach the highest and noblest points of what he really is. It is not true, therefore, that only faith can supply the strength by which to accept and give value to pain. It can be of decisive importance in this endeavor, but the support it provides can also involve the placing of roots in human reason and intelligence, elements which themselves are also gifts of God.

The placing of Hippocrates and the Good Samaritan in tandem is constantly encountered in the whole history of medicine and health care. During this history the Church, during her two-thousand years of life, has shown herself to be a pioneer. This reality illuminates another truth, a truth which has been referred to by the Holy Father. In serving those who suffer, a meeting of all men of good will becomes possible, a meeting which in other fields has proved difficult, if not impossible. Philosophical, religious, political, economic, and social ideas can experience insuperable differences and divergences. Service to anyone who suffers, on the other hand, because it involves an encounter with the most universal and deeply felt of human aspirations—namely, the safeguarding and recovery of health, and thus the advancement and defense of human life—renders an ecumenism of works possible, a reality which constitutes a real bridge towards justice and peace.

Indeed, such an ecumenism of works is more than an aspiration—it is a necessity. And the decision to link together Hippocrates and the Good Samaritan of the Gospel parable is an attempt first and foremost to demonstrate that it is especially in her solicitude for the sick and the suffering, and in the advancement and the defense of life and the dignity of the human person, that the Church—being at the same time the heir to the highest values of each and every civilization—wants to place herself at the vanguard of the difficult advance towards that civilization of love to which, indeed, there is no alternative.

FIORENZO Cardinal ANGELINI

VINCENZO CAPPELLETTI

Where There Is Love for the Art of Medicine, There is Love for Man

The subject of this tenth international conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers requires an understanding of the relationship between Hippocrates and the Good Samaritan. This should take place before the reading of the papers on the various subjects which form a part of the program of this conference. The subject of the conference emerges clearly in the title of the first paper: "Where there is Love for the Art of Medicine, There Is Love for Man." A failure to deal with this subject at root would mean that it would be impossible to deal with the specific question expressed in the title of this paper in a suitable and convincing fashion.

The Samaritan is at the center of a very important allegory related when Christ was preparing for his journey to Jerusalem. The Samaritan is the central symbol of a definitive lesson on the essence of the divine and the meaning of the Incarnation. The figure of the Good Samaritan is used to make people understand the law of love which had previously been written into the text of the Old Testament but which from that moment on was to be of primary importance in the New Testament. A man of law asks Christ what he must do to obtain eternal life and Jesus refers him to the precept of the ancient law. According to this law one must love God with all one's heart and one must love one's neighbor as oneself.

The figure of the Good Samaritan is employed to explain the meaning of the concept "neighbor." The man who is robbed by thieves and left for dead on the road is our neighbor. The Samaritan who was traveling on the road sees him, helps him and takes care of him. This story told by Christ is both sublime and of an astounding simplicity. The love of God who is love enters into the relationship between these two men, two individuals who come into contact with each other on an unimportant road on their journey through life. The Gospel according to Luke is certainly built upon oral tradition and perhaps upon written tradition, and it certainly has great charm. Yet in this parable it reaches one of its highest points.

The parable of the Good Samaritan presents lived and expressed love as the answer to the question posed by the learned man of law who wanted to know how man could gain eternal life. Here we touch in essential terms upon the core message of the Good News: upon the idea that love should be at the center of being. This, of course, was how God had presented himself to Moses. Love in God for the world and for men, love in men for God but also for all other men and for ourselves, and without differentiation. Love informs everything and redeems everything, even the relationship between our egos and ourselves.

Love is a fundamental and universal expression of an awareness of a rule which tells us how we should be at all times. This rule is parallel to the primary relationship which exists between God and the world which He created, a relationship which includes man. This rule springs from a universality which is rooted in divine origins. But let us return here to our analysis. The Good Samaritan is a polysemic (as we would say today) symbol. He is also the model for the relationship between a doctor and his patient, a model which has as its pre-condition the idea that the doctor embodies the universality of Christian love and the full spectrum of its expressions. But that doctor would not be a Good Samaritan unless he had what the Good Samaritan symbolizes: love. But was there love, we may ask, in Hippocrates?

Here we must pause for a while to give our discussion a richness which it would not otherwise have. If Hippocrates were foreign to the concept of love and of reality lived in human love, the relationship between the Good Samaritan and Hippocrates would appear to be a rather contrived linkage—full of good intentions certainly, and generative of uplifting thoughts, but in essence without historical foundation.

But such is not the case. At the time of Hippocrates there was a debate about love and a profound theory was current about its meaning and role. First of all let us establish some historical and chronological dates. Hippocrates was born in Kos in 460 BC and died in Larissa in Tessaglia in about 370 BC. Socrates was born in 470 BC and died in 399 BC, the victim of Athenian democracy. Plato was born in Athens in 428 BC and died in 348 BC. Plato was the youngest by a generation of these

thinkers. Pericles is also of importance when we consider the political and cultural background of interest to our inquiry. Pericles lived between 495 and 429 BC and was a vital and dominant figure of Athenian life, especially in the three decades between 461 and 429 BC. In the lives of all these personalities the two decisive victories of the Athenians over the Persians, those of Marathon in 490 BC and Salamina in 480 BC, clearly cast a very long shadow.

Our question can be re-formulated: Was there a spiritual need during the Athenian age of Pericles to approach the subject of a relationship not only between man and man, but also between man and the nonhuman, within a context of love, a context framed between desire and giving, between possession and good will? And if there was, it is clear that Hippocrates could not have been alien to it or have ignored it. Equally, by one or by many of the roads by which human thought pervades the world, the argument and search for love must have touched and shaped the starting points in part implicit and in part explicit—of that extraordinary structure which was the Hippocratic doctrine of medicine.

The subject of love certainly found real space and importance in the Athens of Pericles, and more specifically in a circle to which Hippocrates belonged—the circle of the *Kaloi Kagathoi*, those men who had the privilege of being able to dedicate themselves to discussion, debate and banquets. The same may be said for all the debates and all the friendships of those years which are to be found in the *Dialogues* of Plato. Hippocrates appears on two occasions, in the *Phaedrus* and in the *Protagoras*, because of the fame and the prestige which his thought had won for him.

In the *Phaedrus*, in particular, Hippocrates looms very large because of the observations made by Socrates regarding the relationship between behavior and the nature of the soul, and between the nature of the soul and the nature of everything. Phaedrus declares: "if Hippocrates is right then one cannot understand the body without a similar approach"—without, that is to say, an overall view. Hippocrates is referred to in the *Protagoras* in a less incisive and overt fashion. Socrates asks Hippocrates, one of the participants in the dialogue but in fact a mere namesake of the Master of Kos, what he would expect to receive from Asklepiades in exchange for money. The answer of the doctor Hippocrates is that he would expect to receive knowledge about medicine.

The *Protagoras* is dedicated to an analysis of sophistry but the *Phaedrus* is concerned with love and sees it as a madness in the sense of a divine exaltation, a delirium which comes from the gods and which is expressed in prophecy and poetry. Socrates and Hippocrates were contemporaries and also of the same age. They both left a lasting mark on the civilization of subsequent centuries. The latter was certainly known to the former, and it is probable that the former was known to the latter. The circle of the optimates was narrow and we know from his biographers that Hippocrates spent much time in Athens and held his medical school in that city. This circle acted to form and promote a number of relationships and friendships, such as that between Hippocrates and Thucydides, which we come to learn about more through the existence of shared ideas than through written evidence to the effect that certain individuals knew and spent time with certain other individuals.

In this way the approach of Socrates, and of the intellectual world around him, towards loving and love could not fail to reflect the basic formative elements of the conceptual framework employed by Hippocrates, and in the same way could not fail to leave a profound mark on that framework. The development of the dialogue in *Phaedrus* is magnificent but the argument about love which Socrates expounded, or is said to have expounded, in the house of the playwright Agathon, and which we learn about through the *Symposium*, is worth nothing. Agathon attempts a praise of love but Socrates says it does not convince him. Agathon, he says, reminds him of Gorgias and the fallacy of the Sophists: he believes he must say the truth about the object which is to be praised, and at the same time attributes to that object great and beautiful things whether the object actually possesses them or not.

But the truth must be said about love and Socrates declares that he follows the path outlined to him by a foreigner from Mantinea, a woman called Dìotìma. She is a foreigner, it should be observed, in the sense that she is outside the Athenian polity. She performs the same role that the foreigner from Elea performs in convincing fashion in the work of the Sophist school she raises doubts, opens up new perspectives, and displays uncertainty about the proposed meaning of being. Dìotìma had explained to Socrates, who then repeated the idea at the banquet given by Agathon, that love is the wish for something which one does not have; it is something between the mortal and the immortal; it is a great demon which transmits the world of men to the world of the gods and the world of the gods to the world of men.

Love was born because Penia (poverty) was made pregnant by Poros by means of a trick at a banquet given to celebrate the birth of Aphrodite. Love is as poor as its mother and as rich in cunning as its father. Furthermore, "what it manages to acquire always slips away through its fingers." Love is the lover and not the loved. For all people, great and treacherous love is a wish for what is good and for happiness. But at the summit of happiness there is immortality. This is to be reached through physical and ideal procreation, achieved by the child and by the outcome of thought. There is a love of ideas and of science, and in these love finds its own identity which lies in the poor condition of man, in poverty.

Love, it should be repeated, is in the lover and not in the loved. And for this reason the idea does not love, and thus it does not love the highest of ideas—God—in the works of Aristotle. Attempts have been made to go straight from the *Symposium* to the twelfth book of Aristotle's *Metaphysics* in order to deduce the presence of another concept of the divine and to explore the possibility that love might be found within that concept. Or to see, rather, if perhaps the highest of the classical meanings of God might be that of a God who loves the cosmos of nature and thus also loves man who forms a part of that cosmos.

No trace of love is to be found in the God of Aristotle. The ideas and observations of Socrates reflect and express the insights and intuitions of a whole world, an entire wisdom, a whole culture. We read: "If, therefore, God is eternally in that happy condition in which we sometimes find ourselves, then he is a wonderful thing. But if he is in a higher condition then he will be an even more marvelous thing. Well, He is like that. And He is also alive. This is because the act of understanding is life, and He is that act—that act which, being for itself, is in Him supreme and eternal life. We believe that God is the perfect eternal living being, and that He has constant life and eternal existence. We believe that this is God."

Being has united itself with life and with thought, and thought has itself as its object—" noesis test noeseos." This is another achievement on the road which leads to the Christian Good News, something which concentrates upon a love which is not poverty but wealth, which is not only a reality of the lover but also a reality of the loved, and these opposing elements are united by the same force. This force is that substance of life which Aristotle drew near to through his linking of it to the divine. Poverty, desire-wealth, gift—here we have an obvious analogy which stares us in the face. On the one hand the relationship which Hippocrates had with the spiritual horizon to which he belonged. On the other the Good Samaritan and his relationship with the truth which he perceived and experienced. Hippocratic medicine loved suffering and death principally in order to discover their causes, their mechanisms, and their symptoms.

Hippocrates is a metaphysician and not a mere physician as described by Socrates in the *Phaedrus*. As a metaphysician he had elaborated a notion, the idea of "hekaston," a concept which preceded the Aristotelian notion of "tode ti." In Hippocrates the individual is this last in Aristotle, and this last is a transcription of "ousia," the substance. The first and third books of *Epidemie*, one of the most perceptive of the texts which can be attributed to the Homer of medicine which Hippocrates was to become, reflect an approach which is almost ecstatic in its observation of illness and the sick person, death and the dying. There was so much to learn, to record and to investigate. And this out of love of, or rather yearning for, the unknown. Hippocrates loved the sick man is a Socratic sense, as is borne out by the passage which expressed the conceptual framework of his diagnosis approach and its associated semiology:

"These are the phenomena connected with illness from which I draw my conclusions—conclusions based on what is shared and what is particular in human nature; on illness, on the sick, on diet and on who prescribes it (upon which depend many favorable and unfavorable consequences); on the general and specific constitution of heavenly phenomena and of each region; on the customs, regime, the way of life, and the age of each person; on what is said; on characteristics, silences, and thoughts; on sleep and insomnia, on dreams—when and how they are experienced; on involuntary gestures—the pulling of hair, scratching, and crying; on paroxysms, faeces, urine, sputum and vomit; and on the connections between illnesses – those which come from the past and those which will arise in the future; on abscesses, and, if they are not a sign of death or crisis, on sweating, shivering, cold, coughs, sneezing, hiccups, breathing, belching, flatulence (whether silent or loud), hemorrhages, and hemorrhoids. The analysis is carried out on the basis of all these elements and what they lead to."

Christian medicine, carrying on from the Good Samaritan, would not only bestow love upon suffering but would also continue the path trodden by Hippocrates by becoming a theory and metatheory of life and constituting a rich source of insights and hypotheses which act through observation, as takes place is all branches of science. The wonderful flowering of hospitals and similar institutions would not be the only element to receive the fruit of a love-wealth which comes from God who is love. Medical science would also gather that fruit. We cannot not declare ourselves Christians—to repeat the title of a very famous work by Benedetto Croce which was published in 1942—in the sphere of modern science and in its powerful expression, namely contemporary science.

Love, life and logos-thought represent *circumincessio*—a splendid concept which comes like many other fundamental concepts of its time from the conciliar period—in the conscience of man. One loves through knowing and one does not know except in God and with God, humbly bearing witness to his definitive substance love. Love-charity is love-knowledge: this is what the open tradition of the example of the Good Samaritan owes to the Good News. But all this is everything in medicine, in basic terms and in each individual act which the doctor performs every day and during every hour of his work.

Professor VINCENZO CAPPELLETTI
Vice President and Scientific Director of the Italian Encyclopedia, *Rome*

PAUL POUPARD

"A Man Went Down From Jerusalem to Jericho" *(Lk 10:30)*

Introduction

Among the most powerful, personal, pastoral and practical parables that Jesus taught is that parable of the Good Samaritan. It is a parable that is powerful, for it speaks of the power of love that transcends all creeds and cultures and "creates" a neighbour out of a complete stranger. It is a parable that is personal, for it describes with profound simplicity the blossoming of a human relationship that has a personal touch even physically, transcending social and cultural taboos, as one person binds the wounds of another. It is a parable that is a pastoral, for it is replete with the mystery of care and concern that is at the heart of the best in human culture, as the Good Samaritan reaches out and ministers to his new—found neighbor who is in dire need of help. It is a parable that is primarily practical, for it poses a challenge urging us to cross all barriers of culture and community and *to go and do likewise!*

Whenever we read and reflect on this parable of the Good Samaritan, we are moved by the depth of its simplicity. It speaks to our heart. It can even trouble our conscience. It is a parable that proves convincingly *"that the word of God is something alive and active: it cuts more incisively than any two-edged sword"* (*Hebrews* 4:12). And similar sentiments stirred within me as I listened to the Hippocratic Oath.

Even though the Oath and the Parable stand centuries apart, there is a bond that links them together for they both express and share a common concern: a commitment to, I would like to state, *"the gospel of life"*; a commitment that stems from a profound respect and concern for the human person. *"Every individual, precisely by reason of the mystery of the Word of God who was made flesh* (cf. Jn 1:14), *is entrusted to the maternal care of the Church. Therefore every threat to human dignity and life must necessary be felt in the Church's very heart; it cannot but affect her at the core of her faith in the Redemptive Incarnation of the Son of God, and engage her in her mission of proclaiming the* Gospel of life in all the world and to every creature (cf. Mk 16:15)."[1] It is precisely this commitment and concern that will engage our reflection and sharing over the next three days of this Tenth International Conference organized by the Pontifical Council for Pastoral Assitance to Health Care Workers. On paging through the agenda of this Conference, I notice that various speakers have been assigned topics, that will throw light of, from a diversity of interdisciplinary dimensions, the phrase "From Hippocrates to the Good Samaritan". Suffering, the care of the sick; healing wounds; the doctor, a man for all; medicine and morality; women in the history of the care of the sick—are some of the themes that will be dwelt on. On my part, as President of the Pontifical Council for Culture, I propose to offer a prayerful but practical meditation on the Parable of the Good Samaritan.

The man, we are told, was on his way from Jerusalem to Jericho. Jerusalem was the holy city where the Temple was located, where Yahweah had chosen to make His dwelling place. It was thus a symbol of the divine and the sacred. In contrast, in Scripture we often find Jericho standing for the world. As Origen put it, *"...the man on his way from Jerusalem to Jericho falling among thieves, represents Adam driven from paradise into the exile of this world. And when Jesus went to Jericho and restored the sight of the blind men, they represented all those who in this world suffer from the blindness of ignorance, to whom the Son of God comes."*[2] Jericho is in a sense a symbol of *secular culture*. And *that* man who was on his way from Jerusalem to Jericho rep-

resents the whole of humanity, as a matter of fact all of us. Like him, are we not too on a journey? For are we not all pilgrims travelling together? Somewhere along the path, we are waylaid and robbed, deprived and stripped of what is best in us, the spark of the divine and the sacred! Religion, which expresses our relationship with God, like the sacred, is at the very heart of culture. And yet as Pope Paul VI has noted: *"The split between the Gospel and culture is without doubt the drama of our time, just as it was of other times."*[3] What is our response as Church, to this body of humanity that lies wounded and waylaid? Do we not need to tend it and restore it to its pristine health and glory? I propose to approach this great story from three angles. It is a parable that calls for Compassion, challenges us to Commitment and ends with the joy of Communion.

1. The call to compassion

There is a world of a difference between mere pity and compassion. Pity begins and ends with self. And even though it may make us feel for the suffering, it remains self-enclosed for it does not bear fruit in action. At the most, pity ends with a sign or a mere shrug of the shoulders. Compassion, on the other hand, urges us to move out of ourselves. For it makes us not only *feel for but feel with* those who suffer. To show compassion, therefore, is to suffer with the wounded and the suffering, to share their pain and agony. While it is true to say that we can never *fully enter into another's pain* and that we more often than not remain outside as silent spectators to another's agony, compassion helps us in some small way not only to feel with but *to feel in* the one who suffers. This is how Jesus, the Good Samaritan par excellence, showed compassion. He *suffered with and suffered* in the persons to whom he ministered. He felt their hunger, He sensed their sorrow, He understood their pain, He sympathised with and befriended sinners, He touched the ostracised. Jesus assumed a back that He might feel the pain of being scourged *"for the high priest we have is not incapable of feeling our weaknesses with us, but has been put to the test in exactly the same way as ourselves, apart from sin"* (Hebrews 4:15). Centuries before He was born the prophet Isaiah had stated: *"Yet ours were the sufferings he was bearing, ours the sorrows he was carrying...; he was being wounded for our rebellions, crushed because of our guilt; the punishment reconciling us fell on him, and we have been healed by his bruises"* (Isaiah 53:4-5).

Compassion, does not leave us indifferent or insensitive to another's pain but calls for solidarity with the suffering. Solidarity *"is not a feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far. On the contrary, it is a **firm and persevering determination** to commit oneself to the **common good;** that is to say, to the good of all and of each individual because we are all really responsible **for all**."*[4] At times we can be like the priest and the scribe who, on seeing the wounded man, passed by on the other side. We can be silent spectators afraid to involve ourselves and soil our hands.

We can easily find parallels in contemporary culture. The visual media today bring right into our homes horrifying scenes of war and violence, of hunger nad want, of sickness and disease, of natural catastrophes like floods and earthquakes. We run the risk of being lulled into a culture of watching passively, of doing nothing. Instead of being actors, we end up by being mere spectators. Compassion demands that we *get out of ourselves* as we

reach out to others in need. It makes us emerge from the comfortable cocoon of our self-enclosure and reach out in love and service to those who need our help.

The concept of health need not be so narrow as to be restricted to mean mere physical or bodily well being. In a symbolic sense health takes on a much wider significance. There are whole societies and cultures *"on the other side of the road"* that lie *"wounded,"* waylaid and deprived by the dis-values of consumerism and materialism, stripped of what is best and most beautiful in human culture, because they are devoid of, and at times hostile, if not indifferent, to God. We have been, culturally speaking, so dehumanized as to have lost the sense of God.

And, over the years, we have gone a step further by nurturing non-belief, resulting in religious indifference. Indifference is worse than hostility. The hostile person at least acknowledges the presence of the other while reacting violently to it; the indifferent person, on the other hand, ignores the other and treats him as if he did not exist.

That was the kind of indifference and insensitivity shown by the priest and the Levite who passed by on the other side, leaving the wounded and waylaid traveller unattended. It is alive in today's anti-culture of isolation and triviality.

But our greatest depravity is that we can lose our sense of God. And with the loss of the sense of the Fatherhood of God, it must of necessity follow that we lose also in the process the sense of the brotherhood of man. Even though we may deny or be indifferent to the existence of God, what fills us with hope and optimism is that the God of the Christian is a God Who rises from the dead, a God Who revives and renews, a God Who restores hope as He rises phoenix like from the ashes. It is precisely to such cultures that have become godless or religiously indifferent, that have become dormant and dead, that the Church as a continuation of Jesus Christ, the Good Samaritan in time and space, needs to reach out and minister and to offer the Good News. These are the very cultures that silently plead for our active involvement. When the Church, and together with her the Christian faith, enters into the flesh of culture the mystery of the incarnation is relived. The Word becomes flesh and dwells among us. He becomes like unto us in all things but sin. *"Without the incarnation there is no salvation: Christ was not born in a void. He took flesh in the womb of Mary; His life was interwoven into the prevalent social and cultural fabric of His time. As the Word of God He spoke in human language, a specific language with a definite cultural heritage. Cultures have been analogically compared to the humanity of Christ. By the mystery of the incarnation, He entered into culture from within purifying it and reorienting it to God Who was to be worshipped in spirit and in truth."*[5] Just as the Good Samaritan entered into the situation of the man lying wounded and half dead and ministered to him, so must the Church enter into these cultures that are wounded and sick and revitalize them by offering them the Gospel of Life.

2. The challenge to commitment

Commitment is one word that perhaps best expresses the attitude and action of the Good Samaritan. He could have, like the priest and the Levite, passed by on the other side. He could have closed his heart and refused to respond to a genuine need.

But he stopped. He stopped to stoop. He stooped to conquer. At that very moment when he stopped and stooped to serve this

stranger who had fallen into the hands of bandits, a neighbor was born. Compassion that is prompted by love is "creative": it creates a neighbor! *"Thus one would be able to speak of a sacrament, of a sacrament of love: when one person makes available his living being, his heart and strength and energies, God causes his creative power to enter and there emerges the miracle of the relationship with the neighbor."*[6]

Ours is indeed a world that is constantly challenged by a growing insensitivity to suffering. We have grown so accustomed to suffering, sickness, and starvation that we can pass by the most gruesome sights without so much as batting an eyelid. We have become so used to seeing soaring skyscrapers provide the background for stinking slums. Did not the world community watch as silent spectators when thousands were eliminated in one of the most massive genocides recorded in history? Life itself has become so dispensable that we have invented euphemistic expressions to quell the qualms of our conscience. We speak today of *"termination of pregnancy"* and *"euthanasia"* as if we could delink them from the sacredness of the human person whose death is being contemplated and executed!

The Church, like the Good Samaritan, is committed to health and life. What makes the reaching out of the Good Samaritan even more poignant is the fact that there was no relationship between Jews and Samaritans. But it is from this reaching out in love that two unrelated persons now begin to relate in love and a neighbor is born! Is it not love that calls the neighbor into existence?

The Gospel text from Luke, Chapter 10, simply speaks of *"a man (who) was once on his way down from Jerusalem to Jericho...."* Have we ever stopped to reflect that this man has no name or nationality, no particular culture or community, no race or religion? He was just a man. Yes, any man, any person in need. Every person in need is my neighbor. *"Everyone who crosses my path and who needs me, no matter of what name, race or religion. Let us not waste time trying to know these things; let us not pass by on the other side. We have to be interested in one thing alone: that this poor person needs me and his name is Jesus!"*[7]

3. The joy of communion

The world we live in is an ocean of suffering. I think of the millions suffering physically in Hospitals, Homes for the Aged, and Terminal Care Clinics. I call to mind little infants too small to understand the mystery of suffering but already big enough to experience it; I remember strong young men crying out with unbearable pain; I know of the aged, so weak and feeble, struggling and gasping for the last few breaths of life. I think of the mental suffering that so many experience: the loneliness of separated spouses, the isolation of orphans who have never known the warmth of a home or the caress of a parent; the agony of the drug addict; the anguish of those who mourn a departed one; the pain of being alone far away from near and dear ones. Suffering is indeed our common heritage. Has suffering a meaning? What is the Christian meaning of suffering? As Paul Claudel has succinctly stated: *"God did not come to take away suffering but to refill it with his presence."* Jesus did not eliminate suffering; He elevated it.

And what ought to be our attitude towards those suffering? *"The parable of the Good Samaritan belongs to the Gospel of suffering. For it indicates what the relationship of each*

of us must be towards our suffering neighbor. We are not allowed to "pass by on the other side" indifferently; we must "stop" beside him. ***Everyone who stops beside the suffering of another person,*** *whatever form it may take, is a Good Samaritan. This stopping does not mean curiosity but availability."*[8] In short, our compassion for the suffering that makes us committed to action to meet their pain, ends in communion when every man and woman who suffers becomes my brother or sister.

It is strange but true that suffering unites. It brings us closer to those who suffer and perhaps even closer to ourselves! For when we are laid low and rendered weak and helpless, we sense more acutely not only our creatureliness before God, but also our solidarity with the rest of humanity. We might forget those with whom we have laughed; but we never forget those with whom we have cried! It is this bond that leads to communion. *"There is something of the clairvoyant in love: a capacity to see through that which lies hidden; to understand that which is not yet presented; to discern that which is to occur."*[9] But there is yet another Person with whom we enter into communion every time we reach out to and serve the sick and the suffering. That Person is none other than Jesus Christ Himself. In no uncertain terms He Himself tells us: *"In truth I tell you, insofar as you did this to one of the least of these brothers of mine, you did it to me"* (Matthew 25:40). We love and serve God as much or as little as we love and serve our neighbor in need. In the last analysis, it is love that counts. St. John of the Cross has summed it all up so beautifully when he says: *"At the evening of life, you will be examined in love."*

Compassion, Commitment, and Communion summarize the message of the parable of the Good Samaritan. It is compassion that makes us feel with and in those who suffer; it is this fellow feeling that leads us to commit ourselves in love and service to them in their need; it is this commitment that brings about a communion of love not only with those who suffer, to whom we minister, but also with God Himself.

Conclusion

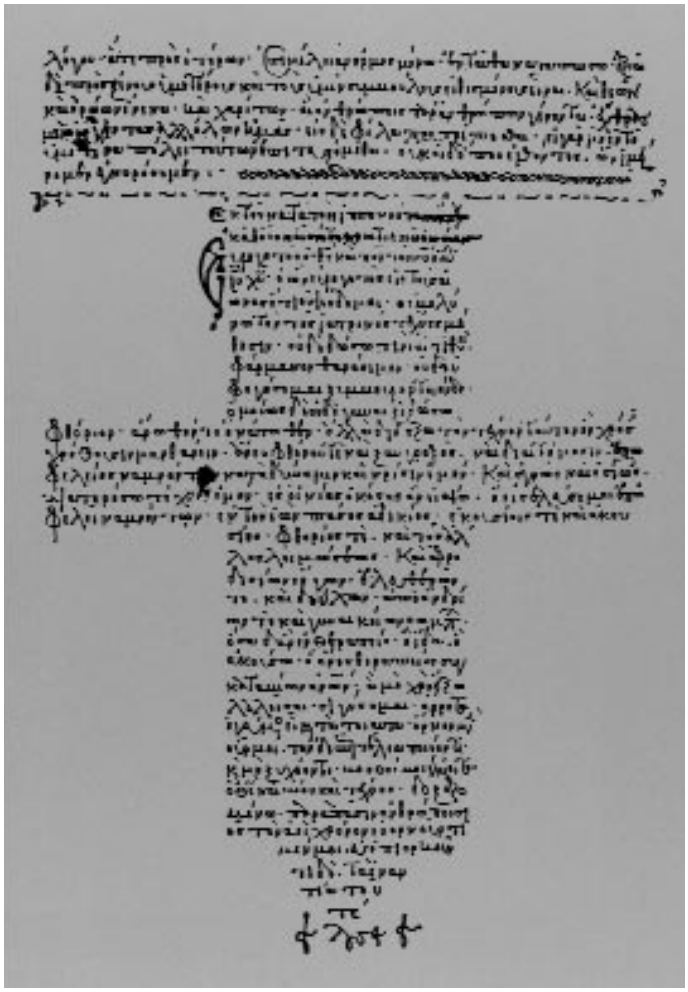
I would like to conclude this meditation with a little anecdote. A rabbi was once instructing his disciples. In the course of his teaching he asked them: *"When does the day begin?"* One answered: *"When the sun rises and its soft rays kiss the earth, gilding it with gold, the day has begun."* But this response did not satisfy the rabbi. Yet another disciple ventured: *"When the birds begin to chorus their lauds and nature herself bounces back to life after the night's slumber, the day has begun."* This reply, too, did not please the rabbi. One after the other, all the disciples made bold their answers. But with none of them was the rabbi pleased. Finally, they gave up and all, agitated, asked: *"Now,* ***you*** *tell us the right answer! When* ***does*** *the day begin?" And the rabbi answered calmly: "When you see a stranger in the dark and recognize in him your brother, the day has dawned! If you do not recognize in the stranger your brother or sister, the sun may have risen, the birds may sing, nature herself may bounce back to life. But it is still night and there is darkness in your heart!"* It is love that gives us eyes to see, a heart to feel, and hands to help. *"The call of the Christian is to share this (love) generously on the different roads travelled by humanity today, roads that are new and sometimes dangerous, but always open to people on the move...."*[10] My earnest prayer this morning, as we begin our deliberations, is that each of us may be filled with that light of

love, that will urge us to move out of ourselves and reach out to others in need, just as the Good Samaritan did to the man who was on his way from Jerusalem to Jericho, to this body of humanity that, on its earthly pilgrimage, lies wounded and waylaid, stripped of what is deepest in its culture, and infuse into it anew a sense of hope, health, and happiness impregnating it with the divine and the sacred and thus restoring it to its pristine glory. In those telling words of St. Irenaeus: *"The glory of God is humanity fully alive and the life of humanity is the vision of God."*[11] Then will this parable of the Good Samaritan come alive and speak to our hearts today, for then we shall know who is our neighbor and fulfill the command of Jesus to that lawyer in the Gospel narrative: *"Go, and do the same yourself."* We are invited into something beyond all law, all old law. We are challenged into the commitment and communion of the new commandment of Christ.

PAUL Cardinal POUPARD
President, Pontifical Council for Culture

[1] JOHN PAUL II, *Encyclical Letter Evangelium Vitae,* 1995, no. 3.
[2] ORIGEN *Homilies* 6,4 quoted in Office of the Readings for Thursday, Week 10 of the Year.
[3] PAUL VI, *Apostolic Exhortation Evangelii Nuntiandi,* 1975, no. 20.
[4] JOHN PAUL II, *Encyclical Letter Sollicitudo Rei Socialis,* 1987, no. 38.
[5] *Rooted in Cultures... Fruitful in Christ,* Office of Education and Student Chaplaincy, F.A.B.C., Manila, 1995, p. 16.
[6] ROMANO GUARDINI, *Volontà e Verità,* Morcelliana, 1978, p. 149.
[7] EDWARD CARDINAL PIRONIO, *"Homo Quidam," Dolentium Hominum,* 1986, no. 1, p. 8.
[8] JOHN PAUL II, *Apostolic Letter Salvifici Doloris,* 1984, no. 28.
[9] ROMANO GUARDINI, *op. cit.* p. 150.
[10] CARDINAL PAUL POUPARD WITH MICHAEL PAUL GALLAGHER, *What Will Give Us Happiness?* Dublin, Veritas, 1992, p. 124.
[11] *Adversus Haereses* IV, 20,7.

Vade et Tu Fac Similiter



From Hippocrates to the Good Samaritan

DIEGO GRACIA GUILLEN

The Hippocratic Oath in the Development of Medicine

Introduction

The thesis which I will seek to propose and to advance in this paper is that the Hippocratic oath has not only been the most valuable document of the entire history of Western medicine and the paradigm of medical ethics but has also been the guiding model for all codes of professional ethics. The message of the Hippocratic oath is that professional activity is a form of public obligation, a compact made before God which requires the practitioners of that profession to achieve and promote the very highest grades of perfection, that is, to achieve excellence itself.

In order to advance and defend this thesis I have divided this paper into three parts. The first part will analyze the sacred or religious character of a profession. The second will seek to show how the Hippocratic oath is a paradigm for the promotion and achievement of professional excellence. And the third, to conclude, will study professional excellence in medicine and will analyze the literary traditions which revolve around a figure who is repeatedly described as "the perfect physician."

I. The Profession: A Sacred Activity

The word "profession" has a religious origin. The Latin word *profiteor,* to profess, like the term *confiteor,* to confess, had a religious meaning in Latin and thus by extension in the Latin based languages as well. This religious meaning referred to the public profession of a faith or to religious consecration. A "professed" person, therefore, was a person consecrated to a ministry who "confessed" this fact in public. The medical doctor, therefore, like the priest, was a person who was consecrated to a form of ministry, and as a part of this process this fact was publicly recognized.

During the Medieval period the term *professio* did not lose its original meaning of religious consecration. Indeed, the opposite was more the case. The classic examples of "professions" in this sense were the *professio monastica* (participation in the rules of monastic life through a public and solemn undertaking to respect vows and rules, and this after a year of trial or of being a novice), and *professio canonica* (the public recognition of the jurisdiction of the bishop by his clergy and those faithful to him). During the last centuries of the Medieval period it was from this background that the term "profession" was introduced into the Latin-based languages but at the same time the original religious meaning of the term which involved the idea of public profession of faith or of religious consecration kept its sense. Even today in our languages expressions such as "profession of faith" or "to profess a religion" are still used, and the original meanings of such words and phrases are still more than present.

The medical doctor, like the person who "professes" in the Medieval sense of the term, is a consecrated person in the strong or religious meaning of the expression and not in the broad or weak sense of dedication to a ministry. We should remember that the word *sacrum,* unlike the term *profanum,* evokes the idea of belonging to a world of the divine and that the verb *consacrare* involves the dedication of something as an offering to a divinity, the idea of offering it to the gods or of putting it at the service of the gods. This is the original meaning of the phrase *sacrum facere,* from which we obtain the noun *sacrificium,* and also derive the appellation of *sacerdos* to describe those people who perform this kind of service.

I have outlined the linguistic roots of these terms in order to understand not only the specifically and clearly religious realities they describe but also those forms of activity which are not so characteristically religious, medicine for example, or more generally what we today term professional activity. Leaving aside the question of whether the practice of medicine was at the outset an activity linked to the role and duties of priests, it is nonetheless clear that in the most advanced forms of human culture, such those to be found in ancient Greece and ancient Rome—where indeed medicine had acquired a very well defined secular status—the medical doctor continued to be to a certain extent "sacred" or "consecrated."

This was not because the physician was a priest in the narrow sense of the term but because in a certain way he had God as a witness or guarantor of the rectitude of his professional activity. Hence the phenomenon of the signing of a pact or of swearing to exercise his profession in a correct and upright way which was expressed in the taking of an oath. There were also activities which were so important, even though they were not directly religious in character, that they needed a religious bond such as that expressed in the taking of an oath. And God himself performed the function of a witness in this procedure. Both religious and non-religious oaths thus became of great importance in people's lives.

We know that some professions were formed in Greece along the lines of the profession of priesthood.

For this reason they developed the idea of a form of professional responsibility which was more religious in character than legal. We should remember that the word "to respond" and all its present-day descendants to be found in the Latin-based languages come from the Latin word *spondeo* whose original meaning refers to committing oneself to a solemn undertaking which is religious in nature. The most frequent example of this was where the father undertook *(spondet)* to give his daughter *(sponsa)* in marriage. We can thus understand more clearly the nature of the ceremony of "betrothal" *(sponsalia).*

From the term *spondeo* we derive the word *rispondeo* which means to respond or to answer but in the precise sense of "fulfilling an undertaking which has been solemnly agreed to." A. Ernout and A. Meillet add that this term at the outset belonged to religious language. This is seen especially clearly in the language of the ancient Greeks where *spendo* refers to the rite of libation and to the obligation which springs from that rite. This religious rite involved the pouring of a certain quantity of wine on the ground, on the altar, or on the victim of the sacrifice, at the time of the declaration of the pact. When this pact had been made it then had religious and moral force. Thus it was that *spondere* came to mean "to undertake," to "commit oneself" and "to promise." To respond thereby means to pledge oneself to someone or to promise something, and the responsibility, the quality or the condition of who promises or becomes pledged.

It is important not to neglect this initially religious meaning of responsibility because it can clarify the "prelegal" or "metalegal" element which is to be found at the roots of this term. For this reason it is very helpful to once again refer to the paradigmatic example of the responsibility which is to be found in the promise to give oneself in marriage. The commitment to an absolute and eternal giving of oneself can thus in the final analysis only be understood as being based on reasons which are "extralegal" or "translegal." The act of indissoluble marriage can be an enormous act of responsibility between two individuals but it seems to go beyond the boundaries of normal legal categories. A legal contract between two people can always be revised; indeed, it can be terminated by mutual consent. Thus it is that it appears that one can speak about two kinds of responsibility, one which is "strong" or moral and one which is "weak" or legal. The first would seem to be that which is present between marriage partners in a historical sense and the second appears to be that kind of responsibility which is necessarily involved in any kind of legal contract. What do we mean by professional responsibility and of what does it consist? Is it a weak or a strong form of responsibility? My answer is that just as there are two types of responsibility—those which are weak and those which are strong—so in the same way there are

two types of occupations, those which are strong and those which are weak. Traditionally these latter have been called, in the first instance, "professions," and in the second, "occupations." In Western history the strong professions or the professions in the strict sense of the term have been characterized by having a kind of strong responsibility just as the occupations have always had a responsibility of a legal character, and the same time the professions in the strict sense of the term have had legal impunity in order to be bound by strong or legal responsibility. Because of this one can safely assert that in a historical sense both forms of responsibility—that is, both moral responsibility and legal responsibility not only have not accompanied one another but have been in opposition. Thus it is that the enjoyment of strong responsibility has been exempt from legal responsibility and vice versa.

Professions which are professions in the authentic sense involve the highest level of moral responsibility and thus also enjoy absolute legal impunity. By legal impunity I mean *de jure* impunity, and thus the absence of legal rules or regulations which would allow the practitioners of these professions to be judged or put on trial. If one analyzes the history of medicine one can see the narrowness of these norms and their circumstantial character. This explains that *de facto* impunity was practically total. Except for certain very exceptional cases the medical practitioner has in fact enjoyed marked impunity, even though, circumstantially, he has not enjoyed this impunity because of written law.

Furthermore one can observe, without fear of falling into error, that in traditional terms not only has moral responsibility usually been separated from legal responsibility but that the first has been protected from the second. The authentically responsible professional was by his very nature immune to legal process. Naturally enough those professions that I have deemed strong professions or professions in the strict sense of the term involve a lower number and range of human activities, which in basic terms are three in number: priesthood, kingship (and by extension the dispensation of justice) and, finally, medicine. By tradition these professions involved consecrated people who bound themselves by a public oath before God and who were called upon to have great ethical responsibility, a status which was accompanied by broad legal impunity. The classical thesis was that penal and legal control sufficed in the case of manual occupations but that in the case of the professions what was required was a total commitment and undertaking, something which in itself had to be religious and moral in character.

II. The Hippocratic Oath: A Paradigm of Professional Excellence

The Hippocratic oath can be fully understood when placed within this general context and framework. My thesis is that this oath was the paradigmatic document of this "priestly role" or "professional role" of priests, kings, judges and medical doctors. This role was characterized

by the possession of a basis which was chiefly religious and fused the very highest "ethical responsibility" with the most complete "legal impunity." All these characteristics, as has already been observed, give a very special status to professions which distinguishes them in marked fashion from occupations. For these reasons it is possible to affirm that the Hippocratic oath is not merely the paradigm of modern ethics but of professional ethics in a strict sense as well.

The Hippocratic oath is a religious document which was probably composed and structured with reference to the wider framework of the dogmatic religions of the time. These religions began the phase of initiation of the novice with the declaration of an oath which involved the neophyte pledging himself to respect a certain set of rules and regulations. In the case of the Hippocratic oath these norms include an undertaking to avoid causing harm, to act to the greatest benefit of the patient, to practice the profession in a pure and holy fashion, to be faithful to the principle of professional secrecy, to refrain from inducing abortions, and so forth. By means of the public declaration of this oath the novice was able to enter the category of those who "professed," or to put it another way, of professional practitioners. In this context the term "profession" had a strictly religious meaning and this characteristic communicated the fact that an inner, private or moral responsibility was present. At the same time, however, this responsibility was accompanied by a strictly enforced and upheld external, public or legal impunity.

This fact enables us to give a rather precise meaning to the term *xyngraphé,* a word which appears three times in the text of the Hippocratic oath. In this way we will also be able to grasp the real nature and significance of the Hippocratic "pledge" or "commitment" which the oath promotes. This undertaking to which the text refers is not primarily or immediately of a legal character. Indeed the term *xyngraphé* is a Greek word made up of two other words: the adverbial prefix *xyn,* which means "with," and the noun *graphé,* which has a number of meanings amongst which "written document" or "legal text." We can observe that what is written commits people to something, it is a kind of solemn promise, and here we can observe why the term *xyngraphé* can be translated by "pledge."

This promise is more religious than legal in its meaning. This has already been observed when we considered two terms which are philologically related to the word *xyngraphé:* namely the word *spondé* which refers to a libation which seals a treaty or an alliance and acts to bestow a solemn or holy character on that agreement, necessarily ensuring that responsibility is involved as well. The other word is *fassio,* the Latin term which means both "to confess" and "to profess." From here we can take another step forward in our argument.

It becomes clear that the pledge or undertaking of the Hippocratic physician, as expressed in the first part of the famous oath, formulates

and defines the "professional responsibility" of the Hippocratic physician in a moral and religious sense, rather than in a directly legal one. The professional figures *par excellence,* namely the priests, the sovereigns, and the medical doctors, establish a kind of relationship with those around them which involves very great moral responsibility but contains the idea that they cannot be legally charged for what they do. The moral pledge involves legal impunity. In my opinion, this is the true meaning of the Hippocratic commitment.

In recent years an interesting controversy has grown up around the meaning of professional morality. In an article entitled "*A Meta-Ethics for Professional Morality,"* Benjamin Freedman draws attention to the special character of "professional morality" as opposed to "ordinary morality." In the opinion of this author, professional morality always has a character which is not ordinary or which is extraordinary, and as a result of this the professional can do or fail to do certain things which are prohibited by ordinary morality as far as ordinary mortals are concerned. In Benjamin Freedman's opinion this explains why professional morality is acquired through an undertaking or contract and he goes on to observe how it distances itself from ordinary morality through the employment of such instruments and methods as the concept of the professional secret.

A little later Mike W. Martin published an article in the same review on the subject of "*Rights and the Meta-Ethics of Professional Morality."* In this article he sought to show how the obligations specific to professional morality lack meaning when they are divorced from the laws of ordinary morality. He also stove to demonstrate that these obligations can only be justified with reference to the laws of ordinary morality. Martin thus went on to argue that the obligation to uphold the professional secret is based upon that principle of ordinary morality which holds that each and every human being has two fundamental and inviolable rights—the right to intimacy and the right to confidentiality.

Freedman answered these arguments in the same year in another article entitled "*What Really Makes Professional Morality Different: Response to Martino."* In this article Freedman sought to draw attention back to the nature of these differences. Arguing that the base is always the same, he stressed the fact that professional ethics are distant from ordinary ethics and places their practitioners on a different and new level. Thus he proposed that: "Professional morality obliges us to engage in acts (or to abstain from them) whose omission (or actual commission) would be immoral, except in the case of the professional identity of the actor." This argument can be carried even further. Professional morality at a practical level helps to distance certain men from a set of social relationships which belong to a determined group and to place them in a situation which can be defined with reference to the following five concepts: "election," "segregation,"

"privilege," "authority" and "impunity." The Hippocratic oath demonstrates this in perfect fashion. The practice of medicine is not a mere "occupation" but a "profession." The professions are very special and particular forms of activity which do not only oblige their practitioners "to do good" (occupation) but to achieve "perfection" *(perficio, perfectio)*. One can thus understand the clearly "priestly" character of the role of the sociologist and the ethical and religious content of the formula of his commitment. The Hippocratic physician was not a priest in the way that the medical doctors of ancient Egypt or Mesopotamia were. He was a person who had a role which was typically priestly in character. Of equal relevance here is the fact that the term *xyngraphé* expresses and in a certain way summarizes the whole of the first part of the text of the Hippocratic oath.

In the second part of the famous oath the physician is called upon to defend his own life and his skill and expertise in a "pure" and "holy" condition. These terms acquire the whole of their meaning when considered in the context of the dispute between ancient Greek philosophers about the nature of sacredness and holiness. At a more specific level this debate can be found in one of the Socratic dialogues of Plato. This dialogue is entitled "*Perí Hosíou"* but is more commonly known as the *Eutiphrón* because of one its principal protagonists. The action takes place on one of the days immediately before the death of Socrates. Eutriphón meets Socrates a long way away from the latter's lyceum, and more specifically near to the Gate of the King where judgments are pronounced. Surprised by the question posed to him as to whether somebody has made some accusations against him, Socrates replies that a certain Meletos: "says that in this way he had acted like a creator of gods *(poiotéstheos)*, and that in seeking to make new gods and thus in not believing in the old gods the accusation against me was made."

Socrates was accused of "promoting innovations in the field of the divine" and of being guided in this endeavor by the *daímon.* Socrates was said to be "impious" *(anósios)* in basing morality and religion not upon the theogonic traditions of Homer and Hesiosos but upon nature and reason. This involved confronting archaic religiosity with another physiological and demonstrable religiosity. The Pre-Socratics had begun this criticism of traditional religion and its associated elements. The Sophists brought this critique to the point of embracing evident lack of religiosity. Socrates was the heir of both these strands of thought and sought to go one step further and to establish the basis for a new physiological form of religious thought and practice. Of what did this consist?

His subject matter, that of his life and his death, is what concerns us here. The great theme of the thought of Socrates was piety or holiness *(hosiótes)* . Eutriphón, on the other hand, acts the part of the defender and the interpreter of the traditional Olympian beliefs. Eutriphón is a wise and respectable Athenian citizen who is a prophet and seer. As an

oracle of the gods he thinks that he knows the secret of who is holy and who is not. He makes this very clear indeed at the beginning of the dialogue. Socrates speaks and outlines what enables somebody to know so much good—"what he considers holy and what he considers impious." Eutriphón then goes on to expound the concept of holiness which is propounded by the religion of the time. This concept is certainly more narrow in character than that advanced by Socrates. It involves the explanation of a number of strange events such as why the best and the most just of the gods—Zeus chained up his father or why, in turn, the father of the father of Zeus committed an act of mutilation.

Socrates could not conceal his feeling of disappointment when faced with the idea that the gods had really done such things. For this reason Socrates presented Eutriphón with the following question: "Do you really believe that such things really happened as is commonly said...? Do you really believe that wars take place between the gods, and that the terrible enmities and struggles and the many other things of the same kind which have been described by the poets and which are represented by artists in the various sacred ceremonies actually took place?" Eutriphón replied in the affirmative and gave his own definition of what constitutes holiness: "A holy man is a man who pleases the gods, and an impious man is a man who does not please the gods."

Socrates answered this statement with the observation that if the gods fight amongst themselves it is because they are in disagreement, because what pleases one of them does not please another, and so forth. This means that if the criteria of Eutriphón are employed things can be at the same time both holy and impious. In order to avoid this paradox the definition has to be altered and it has to be argued that what is holy is what pleases all of the gods and what is impious is what displeases them all. Socrates goes on to ask: is what is holy approved by the gods because it is holy or is it holy because it is approved by the gods? In so doing Socrates turned Eutriphón's criteria against him, criteria which argued that things are either good or bad, either holy or impious by nature, and that this is why the gods love them. If on the one hand Eutriphón believes that what is holy is by definition that which pleases the gods, on the other hand Socrates maintains that the gods are pleased by what is holy, that is, by that which by its very nature has this "essential characteristic."

What is this characteristic? In order to set out his definition, Socrates contrasts holiness with justice. *Hósios* is what is owed to the gods whilst *díkaios* is what is owed to humans. One can also say that holiness is a part of justice, justice towards God, divine veneration or service, in a word *Therapeía.* (This word, as is well known, refers more to the worship or to the fear of the gods than to the medical treatment of humans). Eutriphón likes this approach, an approach indeed which agrees very well with his "priestly" style: "Socrates displays a respectful simi-

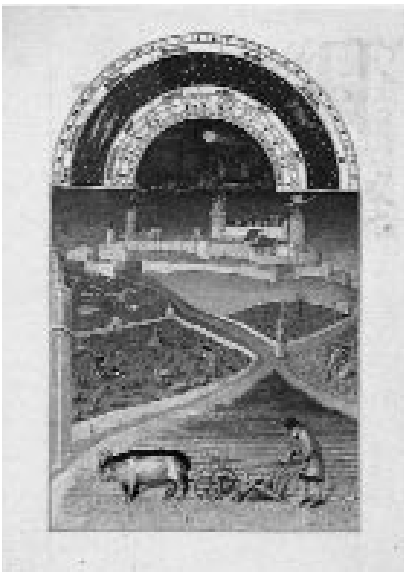
larity to how slaves behave in relation to their masters."

Just as the *therápaina* or female slave dedicates herself to caring for her master so the priest places his life at the service of the divine. In doing this and thus in enslaving himself in relation to purity and goodness, the priest makes holiness his profession. At the end Socrates and Eutriphón seem to be in agreement. One immediately sees, however, that such is not the case. Eutriphón thinks that somebody is holy because that person is at the service of the divine. Socrates, on the other hand, thinks that somebody is at the service of the divine because he is holy. Eutriphón then proceeds to defend the traditional Olympian priest with all the paradoxes he can draw upon.

However, at the end of the dialogue Socrates declares: "I become aware that you would not be prepared to instruct me." By thus downgrading Eutriphón, Socrates seeks to discredit his attributed capacity to be a mediator or a pontifex between men and the gods, that is, he seeks to discredit his role as a priest. In doing this Socrates initiates a new kind of priesthood, his own, towards which and for which he lived and which would bring him to his own death.

After this analysis of Socrates' ideas of "justice" and of "holiness" let us now return to the actual text of the Hippocratic oath. What is the meaning of the term *hósios* which is present in the second verse of the second chapter? First of all there is no doubt that its meaning is physiological rather than mythical. The author of the famous oath is much nearer to Socrates than to Eutriphón. But there is a second problem. In the physiological sense should we understand the term as having a wide and rather vague meaning, or, on the other hand, as in the dialogue of Plato, should we see it as referring to service to the divine rather than to humans? Without doubt we should follow the second path. For this reason a distinction should be made between the criterion of "justice" and the criterion of "holiness." The first should be understood with reference to *díaita* or to the way in which a life is governed and the second should be identified with the idea of *phármakon.* What should be observed about this latter idea?

The word "medicine" or "drug" (a pharmacological entity) has a technical and medical meaning here. It involves the use of natural products to cure illness but it also has its original religious sense of purging or purification. From this point we arrive at the pharmacological clause which calls upon the physician to have "purity." A medicine purifies a sick person and this requires the purity of the physician. This purity is both moral and physical in nature but it also has a religious dimension. We should not forget that the virtues are a gift from God. The *dynámeis* of medicines are the manifestations of the *dynamis* of God. Here we encounter a clearly religious meaning which is not present in the regulation of the *díaita,* a term which was not originally religious in meaning but moral. For this reason it is necessary to act in harmony with the moral virtues of justice—whatever may be the claims of holiness—that religious virtue *par excellence.*



III. Profession and Excellence: The Search for the Perfect Medical Doctor

The content of the Hippocratic oath has given rise during the course of medical history to a tradition about the idea of the "good doctor" or "perfect doctor." From the medical doctor, as from the priest or the sovereign, perfection is expected. But this cannot be reached without the practice of virtue. As Aristotle declared, to know what justice is does not necessarily mean to act in a just fashion.

To act does not have here only the meaning of "act" but also that of "ability." The Latin term *agere* allows both meanings. The abilities or habits emerge from the repetition of certain actions. When the habits which are acquired are good they are called "virtues" and when they are bad they are called "bad." Moral perfection is achieved and expressed only when the ethical consistency and coherence which exists between ideas and actions has become deeply embedded and present over a lengthy period of time, when ways of acting have become a matter of second nature, and thus when virtuous habits are put into practice without the stress and strain of effort and even with pleasure. This is what Aristotle called *bíos,* or "way of life." When thought comes to be a kind of second nature of man, as happens with the philosopher, the practice of the dionoetical virtues becomes a way or form of life, and thus become *bíos, bíos theoretikós*. The man who has a brilliant idea is not a good philosopher—he is a man who has made the practice of dionoetical virtues his way and form of life. The same is true of the practice of moral or ethical virtues, the consequence of which is the appearance of a way or form of life which is truly ethical, something which Aristotle called *bios politikós.* If what a man expresses in his habits is vices rather than virtues, then another form of life appears—what Aristotle termed *bíos apolaustikós.*

Next to these elements there is a specific *bios,* namely *bios iatrikós.* This is the form or the way of life of the virtuous physician. In order to be a good medical doctor it is necessary to possess the intellectual or dianoetical virtues to the highest degree and extent. But given that medicine is an active force and not a matter of mere theoretical knowledge it needs its own specific moral and ethical virtues. In this way *bios iatrikós* is a specific form of *bios politikós.* It is known that Aristotle believed that ethics formed a part of politics. In addition it should be said that the same was true of medical ethics. The medical doctor can manage to be "good" or "perfect" only when he has managed to transform his technical ability and his moral virtue into a kind of second nature, a way of life. The perfect physician is the virtuous physician.

The literature on the "perfect medical doctor" began with the early stirrings and developments of Western medicine. Aristotle himself spoke about the *téleios iatrós* (the perfect

physician) and Galen spoke about the *áristos iatrós* (the optimal physician). The adjective áristos is the superlative of *agathós,* a word which means "*good,"* and when applied to the medical doctor it means that he must possess to the highest degree and extent both the dianoetical or intellectual virtues and the moral and ethical virtues:

"Because in order to know the nature of the body, the differences between the various forms of illness, and the signs which show which remedies are required, it is necessary to be the master of rational science, and in order to persevere in their study it is necessary to despise wealth and be moderate... Indeed, the man who despises wealth and practices moderation, even though this may involve a certain inconvenience, is not afraid. This is because everything which men dare to do in unjust fashion they do under the influence of greed or the spell of pleasure. Thus it is that the physician should also possess other virtues, and this is because these latter follow the former and it is not possible for a man to have one and not the others, being, as they are, linked together as on a string." The most highly skilled physician, therefore, is the physician who possesses both the ethical and the dionoetical virtues. Both categories of virtues are made up of good habits and when they are present and active together they act to form *bços iatrikós,* that is, the way or form of life characteristic of and specific to the good physician, the virtuous physician, or the perfect physician.

This classical tradition continued without great changes at least until the end of the eighteenth century. In 1562 Alfonso de Miranda wrote a book which bore a highly significant title: *Diálogo de la Perfección y Partes que Son Necesarias al Buen Médico.* A few years later Enrique Jorge Enrçquez responded to this book with his own *Retrato del Perfecto Médico*. All of this literature always had two principal features. On the one hand there was the criticism of the contemporary state of medicine and on the other there was a presentation of the ideal paradigm. Enrique Jorge Enrçquez outlined his ideal paradigm in the following way: "The medical doctor must fear the Lord and must be very humble and not proud or vainglorious, and he must be charitable towards the poor, discrete, benevolent, affable and not vindictive. He must know how to keep a secret, he must not gossip, nor must he speak ill of people, flatter or be envious. He must be prudent, moderate and not excessively bold... He should know how to control himself, and he should be honest and reserved. He should be a physician dedicated to learning and diligent. He must work on his art and avoid the pursuits of pleasure. The physician must be educated and know how to give explanations to all kinds of people."

It cannot be in the least doubted that during the eighteenth century (as will be described below) this ethic of "virtue" received a severe blow. It was replaced by the idea of "rights" and "duties." After the Enlightenment of the eighteenth century we all live, as Macintyre has rightly observed, "after virtue," and for this

reason it is the incumbent duty of us all to be "after virtue" in the sense of pursuit. Virtue is in a certain way one half of moral life. The good man is the virtuous man, that man who has turned virtue into a way or form of life. This means éthos, form of life, *bíos* (separate from *zoé*), and thus *bíos politikós.*

We should observe here that the Greek term *areté,* that is, "virtue," did not originally mean moral virtue but a physical condition which enabled an individual to do something well. Perhaps the most appropriate Spanish term here is virtuosidad, which may be translated by the English word "*virtuosity."* Obviously enough, we can say that Michelangelo Buonarroti was a sculptor of virtuosity, or that a certain person is a surgeon of virtuosity. Equally obviously, we are well able to distinguish between a surgeon of virtue and a surgeon with virtuosity. It should be pointed out that the Greek term *areté* is more descriptive of the first example than the second. This is because a surgeon cannot have virtue if he does not have virtuosity. Obviously enough, technical and practical virtuosity is the pre-condition to moral virtue.

So far we have been able to grasp that Plato and Aristotle did not hesitate in the least to speak, for example, about the *areté* of a being without reason such as a horse. A very important passage exists in relation to this point:

"It should be said that virtue perfects the condition of the individual who has that virtue and does good to his work. For example the virtue of the eye does good to the eye and to its function (we can see well thanks to the virtue of the eye). In the same way the virtue of the horse does good to the horse and enables him to run, to bear his rider, and confront the latter's enemies."

After the explanations which have been outlined above, there can be no doubt that the passage should be understood in a certain way: it is clear that Aristotle was not preaching the value of the moral virtues of the horse but its technical virtuosity, the fact that it is a good horse, for example that it might be a good sprinter. The horse which performs its tasks and functions well we describe in present-day language as being an excellent horse. We say that it is an excellent horse and not that it is a virtuous horse. In the same way we say of a person who is blessed with good sight not that his sight is virtuous but that he has excellent sight. As a result it appears more than clear that the best term by which to translate the ancient Greek word *areté* is not "virtue," nor indeed "virtuosity," but "excellence." We can therefore read the passage from Aristotle again, replacing the notion of virtue with that of excellence. The text thus becomes the following: "It should be said that excellence perfects the condition of the individual who has that excellence and does good to his work. For example the excellence of the eye does good to the eye and to its function (we can see well thanks to the excellence of the eye). In the same way the excellence of the horse does good to the horse and enables him to run, to bear his rider, and confront

the latter's enemies."

Aristotle does not stop there but continues in the following way: "if this happens in all cases then the excellence of the man will also be the habit by which the man becomes good and by which he performs his tasks well." The good man is the excellent man and the striving for excellence is and must be the greatest human aspiration. It is no accident that the ancient Greek word *areté* comes from *areíon,* which is in turn the comparative of *agathós,* meaning "good." *Areíon* thus means "better" in the sense of "better" than others, or to put in another way: "excellent." In reality the comparative of what we translate with the term "good" is "excellent," and its superlative thus becomes "most excellent."

We can thus grasp the final and true goal of professional ethics—the striving for and attainment of excellence. The engagement with excellence is the search for perfection, for total quality, for work well done. Excellence means, as Aristotle himself said, doing something well *(eu prattein),* which is in turn a fundamental ingredient of living well *(eu zen),* and thus of happiness and of perfection. The conclusion is more than evident: excellence is the sole and final goal of professional activity.

The relationship between the medical doctor and the patient (or more generically the relationship between the health care worker and the patient) will only be perfect if the medical doctor aspires to virtue, strives, that is,, to achieve excellence. And given that the virtue *par excellence* of social and political life is in Aristotle's opinion *filia* or friendship, it follows that the medical relationship will only be perfect when it involves friendship. Friendship is the moral virtue *par excellence* and it is thus also the fundamental feature of the morality of those who have virtuosity. We can thus see that the

Laçn Entralgo has dedicated an entire book to what he calls "medical friendship." It is usually said and argued that the medical doctor—and the health care worker in general—must be "at the service" of the patient. I believe that this is a very serious error. The old social and legal figure based on servility can never constitute an ideal for human relationships. Such relationships must not be based upon "service" but upon "friendship." Friendship, indeed, is the virtue *par excellence* of human relationships. Perhaps for this reason Aristotle said that friendship was "that which is most necessary to life." And he went on to add that "nobody wants to live without friends, even when that person possesses all other possible goods. Even rich people and those who have high appointments and wield power seem to have need of friends before anything else.... In poverty and in misadventure friends are the only true refuge." However it is precisely in such hard times that friends are less frequent and less present. Down the centuries the following lines, written by the poet Ovid, have been frequently quoted and cited:

Dum fueris, multos numerabis amicos; tempora, si fuerint nubila, solus eris.

One of the darkest moments in our lives when we have greatest need of friends and when they become rather scarce on the ground, is when we are ill or fall sick. The sick person does not want pity—he wants the demonstration of courage and of love on the part of his friends. "Those who experience pain," declared Aristotle, "feel that pain less when their friends come to visit them." *Filía* is love but a trusting and loyal love. Friendship is characterized by trust and by intimacy. It is for this reason that we say that certain friends are "intimate friends." The world of friendship is the world of trust. The three virtues which we term theological are present and active when real friends are involved. These theological virtues are: faith, hope and charity. At the center of these virtues is hope, understood in this context as trust. Indeed, in order for a friend to confide in someone he has first to trust that person—there has to be a "trusting faith." And the friend is confided in because he is loved—there is a "trusting love."

Friendship is more than an ethic, it has much to do with religion. *Agape* or "charity" is usually seen as the virtue *par excellence* of Christianity. But *agape* only leads to perfection when the benevolence and beneficence which characterize this virtue are linked to intimate trust and to that intimate trust which is the great feature of friendship. The result of this, as Edmund Pellegrino and Warren Reich have so accurately pointed out, is "com-passion," something which involves putting oneself in the position of another person and identifying oneself with his experience. Compassion is not pity. It is a human relationship based upon devotion, upon constancy, upon respect for the individual, and upon responsibility. It is, as Reich makes clear, a relationship with another person based upon love, upon benevolence, upon understanding, and upon friendship. *Filça* and *agape* converge and complete each other in compassion. And it is for this reason that it is the most sublime of all human relationships:

I shall no longer call you servants,
because a servant does not know
his master's business:
I call you friends,
because I have made known to you
everything I have learned from my Father (Jn 15:15).

Professor DIEGO GRACIA GUILLEN
Professor of the History of Medicine at the Complutense University, Madrid
Consultor to the Pontifical Council for Pastoral Assistance to Health Care Workers

BRUNO ZANOBIO

The Ethical Dimension of Hippocratic Medicine and Its Specific Relationship to Christian Morality

When I was very kindly invited to make a contribution to this important conference on the subject of the ethical dimensions to Hippocratic medicine and their specific relationship to Christian morality, my first instinctive impulse was to decline such an honor. I was immediately more than aware of the great complexity of the subject which had been proposed to me, not least because of the approach to the subject which is usually employed in the studies of our discipline.

In particular, I immediately noticed that the title of the conference—"From Hippocrates to the Good Samaritan"—went from a historical figure to a symbolical figure, namely a cardinal figure of one of Jesus's parables. Or to put it another way: to a lesson in the form of a story which has the purpose of providing a comparison and an example with a moral goal. We have here two figures which are rather distant from each other in terms of time, who come from different backgrounds—from Hippocrates of Kos of the fifth century before Christ to the Gospel according to Luke (60-70 AD). But these are figures who have been chosen deliberately by the organizers of this conference because to a certain extent they have an important element in common—they are bearers of ethical messages which touch medicine either directly (Hippocrates) or indirectly (the Good Samaritan).

Furthermore, the subject has already been tackled from various angles by a broad range of authors, and this is especially true of the famous "Oath." Of these authors I would like here to refer to His Eminence Cardinal Fiorenzo Angelini, to whom I extend a cordial greeting.

With all these reservations, however, I accepted the invitation. But I will seek to approach the subject as a scholar bound by the conventions of historiographical method and accustomed to the investigation and interpretation of documents, or rather the many kinds of traces of the past which we find in the present. It is not my intention to discuss here the many aspects of the figure of Hippocrates or the many interpretations of his "Oath" in the history of medicine, nor to dwell upon the complex and well known problems relating to the various forms of transmission and diffusion of the literature attributed to the Cos school in the ancient and medieval worlds. Obviously enough, however, my paper will not be able to ignore these factors altogether.

The debate about the ethical dimensions of Hippocratic medicine has always been of notable complexity. Indeed, the levels of complexity have been such that the questions and problems arising from the debate have never in reality been fully settled.

The very definition of "Hippocratic medicine" involves great difficulties which touch upon matters which go beyond the mere elements of this medicine. This is because we can interpret the phrase as meaning not only that approach to medicine expounded and practiced by the school inspired by the teachings of Hippocrates and largely written up in the *Corpus Hippocraticum,* but also that approach which is active today and which invokes the spirit of these teachings, defines, proclaims and presents itself as such, and thereby (so to speak) confers upon those teachings a perennial validity. And here, it may be observed, I do not even touch upon the debate about Hippocratism and Neo-Hippocratism.

When faced with the breadth of the stimuli of this meaning which have entered active medicine, various debates have emerged which have provoked and continue to provoke an examination and the study of the changing relationship over time between the values implicit in the text at the time of its formulation and during the vicissitudes of its evolution until today, and the values specific to medical practice which at times have been in harmony with those of the text and at times have been in contradiction.

On the other hand we well know that the guiding principles that we now express and which appear to us as questions of ethics and professional codes, do not actually come from the short text of the "Oath" to which reference is made but are present in significant, albeit less well-known, fashion in a number of other texts of the *Corpus Hippocraticum.* Jouanna has picturesquely and perceptively defined these texts as "pieces in search of an author," and they are pieces which are homogenous and yet not homogenous at the same time.

Naturally enough, we cannot dwell here upon those questions which have been discussed and debated for a very long time—and which are still the object of inquiry today—relating to the paternity of the "Oath" and of the other texts which will be cited in this paper. Indeed, as regards the "Oath" in relation to the specific interpretation which is of interest to us here today, we should consider the classification given to it by the physician Herozianus, who lived at the time of Nero, and in the first century AD but before Galenus (129-200) compiled the oldest list known to us of the presumed works of Hippocrates. He saw the "Oath" as the authentic product of the thought of Hip-

pocrates and classified it in the "tracts on the arts" together with "law, art, and ancient medicine." This classification indicates that in that epoch Herozianus was reflecting the shared meaning of a normative and behavioral message which is very evident in the text of the "Oath" and the "Law" but which can also be grasped by a non-superficial reading of the "Ancient Medicine" and the "Art."

In order to help the reader I will here present some brief and already known reflections on these tracts. But I will not refer to the "Oath" both because of its fame and because it is the subject of discussion by other authorities at this international conference. As regards the "Oath" I would like merely to make the observation that some scholars and experts have a rather restricted approach to it and interpret it with less emphasis on its ethical content than other commentators. Some people, indeed, believe that in the "Oath" the normative dimension relating to the behavioral duties of the physician prevail over the more authentically ethical dimension in an overall sense.

Ancient Medicine. This belongs to the discourses originally intended to be pronounced before a public of specialists and non-specialists. The reference to Hempedocles gives credence to its being attributed to the end of the fifth century before Christ. The author of "Ancient Medicine" believes that a knowledge of man is only possible through medicine, a view in opposition to those who maintained that philosophical knowledge about man is more important than medicine.

Art. Generally attributed to the end of the fourth century before Christ, this work is a part of the discourses originally intended to be pronounced before a public. In this work the author tries to demonstrate that medicine is an art which is full of resources within, obviously enough, certain limits. At the same time it is a reply to the critics and detractors of the art of medicine.

Law. This is the work, after the "Oath," where perhaps the characteristic elements of Hippocratic medicine stand out most sharply. In this work it is stated, amongst other things, that in order to be a good physician it is necessary to fuse a serious training with natural qualities, and that this training must take place from childhood in a good school of medicine and be promoted by passion for the calling. The piece concludes by comparing the acquisition of scientific knowledge to religious initiation into the mysteries. In the same way the prohibition regarding the revelation of sacred knowledge to non-physicians carries on from the "Oath." Because of its use of the term "dogma"—which does not appear before Plato and Xenophontes—the text cannot be prior to the fourth century before Christ. However it already formed a part of the *Corpus Hippocraticum* at the time of Herozianus who placed it in the category of works relating to art immediately after the "Oath." Echoing once again Jouanna, I would like here to refer albeit briefly to certain texts from the Hippocratic background which contain deontological elements which at times touch upon ethics.

Decorum. This is a short piece on the correct conduct of the physician when he exercises his profession both in his surgery or clinic and at the bedside of the patient. It contains various kinds of advice which conform to the Hippocratic spirit. This work, however, does not form a part of the ancient nucleus of the *Corpus Hippocraticum* and does not appear in the list of Herozianus. It can be dated to the first or second centuries after Christ.

Duties of the Physician (or Testament of Hippocrates). This is a short deontological work which lists the physical, moral, and intellectual qualities which the physician should have. However, it does not form a part of the ancient nucleus of the *Corpus Hippocraticum* and can be dated to the first or second centuries after Christ.

Physician. In this text the author gives advice of both a behavioral and technical character to the doctor at the beginning of his career. In relation to its deontological contents it corresponds well to the more ancient texts and one part is directly based upon the "Oath." The work entered the *Corpus Hippocraticum* rather late, it was not known to Herozianus or to Galenus, and can be attributed to the Hellenistic epoch or to the beginning of the Christian era.

Precepts. This text has essential deontological contents (picture of the ideal physician; criticism of bad doctors) and has a section on medical method which has close affinities with Epicurus (341 BC—271/2 AD). It is not to be found in the list compiled by Herozianus, and according to a glossary of the Vatican codex "Ur. gr. 68" this text belongs to the Hellenistic epoch.

From an examination of the above and from what emerges from the literature, to which I will refer at times in textual terms, the Hippocratic physician emerges as an austere and serene man, a master of himself, possessed of a quick memory, endowed with a great professional seriousness, hostile to theatrical attitudes and poses, gifted with abilities of a technical kind, and in the formulation of his prognoses he avoids engaging in "divinations."

"What the sick person is looking for is not embellishments but relief." (Physician).

"In many instances it is not enough to argue that something should be done. Action should be taken to provide help." (Decorum).

There are however many questions raised by Hippocratic medicine in relation to ethics. I will now give two examples of this.

There are discussions about physicians treating free men and physicians treating slaves. These discussions are rendered difficult by the fact that the Greek term "παιδσ" can mean both "young man" and "slave." It has been observed here that such conduct, deeply influenced by time and place, depended more upon the "society" than upon the Hippocratic physician himself. When consulted, this physician paid as much attention to the sick slave as to the sick free man, and to this extent the Hippocratic physician is in essential terms more up-to-date than Plato. A similar problem arises in relation to the conduct of the physician towards the rich rather than the poor and to what his professional fees should be.

When we come to consider the importance of the "society" of that time it must be remembered that social censorship was of real importance and consequence and could actually destroy the career of a medical doctor, even though this was a period when the responsibilities of the physician were not actually codified in law.

Another problem which arises in relation to Hippocratic medicine and the field of ethics is that of the

possibility the Hippocratic physician has of taking the important decision to not treat a sick person if he thinks that the patient cannot be cured. This approach is very different from that of the Cnido school, which argued that the physician should treat a sick person even when a fatal illness was involved. In reality the problem could not be solved easily because of the varying influential opinions of the day. In *The Republic* Plato declares that "men with expert art, for example the navigator and the eminent doctor, know in their art how to distinguish between the possible and the impossible, and they attempt the possible and neglect the impossible." In the same way Herophilus (third century before Christ) believed that "the perfect physician is able to distinguish between the possible and the impossible." According to the "Art" it is possible to not treat the impossible and Galenus, referring back to the "Art" in his "Commentary with Aphorisms," admits that one can decide not to treat sick people who have been defeated by illness. This leads us to consider the problem of the modern day concept of therapeutic overkill, but this is a subject which in this paper I cannot even touch upon.

However the position of the followers of Hippocrates on the curable and the incurable was not clear cut but could vary according to ideas about the possibility of advance and progress in medicine.

But to return to the texts belonging to the "Art" I would like to point out that they made up a part of the group of works defined as "therapeutic," an appellation which endowed them with the connotation of being teachings which were indispensable to the practice of the art of healing. At that time the question of whether these special areas of knowledge and instruction were a component element in the complete training and formation of the physician and thus constituted an integral part of his healing powers, or whether they had a mere normative importance, was already being raised.

Our impression is that both these aspects were present in the literature of the Hippocratic school and that our interpretation of the ethical questions and dilemmas posed by that school enables us to understand both the normative parts—which seem to prevail in the "Oath"—and those aspects which take the form of chapters devoted to giving instructions about technical approaches and methods.

I will not dwell here upon the extent to which, with what implications with regard to language, and the ways by which, Hippocratic medicine and its ethics spread in powerful fashion through the ancient world. Instead, I wish to turn to another subject.

We can thus have a clear idea, given what has been outlined above, of the ethical dimensions of Hippocratic medicine when the evangelist Luke (an abbreviation of Lucan) gave an account of the parable of Christ about the Good Samaritan. This parable is related by this evangelist alone. It narrates how in going down from Jerusalem (740 meters above sea level) to Jericho (350 meters below sea level) at first a priest and them a Levite saw a man who had fallen victim to thieves who had stripped him and covered him with wounds before leaving him half dead. Both the priest and the Levite saw him and passed on. After them there came a Samaritan—a sinner and atheist in the eyes of Jewish public opinion—who stopped and helped the unfortunate man without paying attention to costs, to nationality or to privileges.

The figure of the Samaritan has a very deep significance. Despite regional and religious antagonism, he helped his adversary to regain his strength and to live.

The parable has given rise to many comments and approaches both for and against the behavior of the priest and the Levite who both ran the risk of becoming impure according to certain religious rules and ordinances. For this reason, the moral conclusion of the parable is that the law of charity always takes precedence over other laws; indeed it can even rightly go against them. "Charity, charity, and always charity!" as an authoritative proclamation would have it.

The naturalness and the incisiveness of the tale told by Luke are such that certain authorities believe that it refers to something which really happened, and that Jesus takes it as a subject so as to come to conclusions about charity towards one's neighbor and to present the real essence of charity. Overall, one is dealing here with a message which has a universal and incontestable value which is to be applied always and in all circumstances. It therefore goes far beyond the ethical dimensions of Hippocratic medicine.

Furthermore one has here a text which expresses its deep meaning through the example of a wounded man and through a wounding, that is to say facts and realities connected to medicine.

Incompetent as I am in relation to ethical, juridical and philosophical questions, I will not dwell upon discussions which have revolved around this fact but I will venture to analyze certain aspects of the subject which provoke the interest of the historian of medicine.

Indeed, one should not forget that:

– Luke, who was Antiochian and Macedonian in origin, and a pagan by birth, soon converted to Christianity. He knew Greek, was a diligent and conscientious researcher, and was the bearer of a notable literary culture. He had these qualities to such an extent that he was also a writer who paid rigorous attention to historiographical method;

– he excludes himself from the list of evangelical eyewitnesses with a sincerity and modesty which are highly praised in the large amount of apocryphal literature;

– the third canonical gospel, which is the most elegant and polished of all the gospels, presents elements which are of special originality. It emerges as a literary work intended for pagans converted to the new faith and especially for Christians of the Greco-Roman world.

– According to authoritative sources Luke studied medicine at Tarsus which was a notable cultural center of Asia Minor, and that the terminology which he used in relation to illnesses and healing is, when compared to the language used by the other evangelists, the most detailed and the most in line with the works of classical medicine; Luke was the beloved physician of St. Paul, indeed his "sectator" (Irenaeus, second century after Christ), and that he accompanied St. Paul on his various journeys, including the eventful voyage (involving a shipwreck near Malta) from Cesarea to Rome. Furthermore, Luke (who died in Beozia at the age of eighty-five) was in Rome when Paul was beheaded in that city in 65/67 after Christ.

Bearing in mind what has been said above, one can also ask if, and

to what extent, Luke knew about Hippocratic medicine and its "Oath." For this reason, the first specific meeting between the ethics of Hippocratic medicine and Christian morality could also have taken place during the first difficult years of Christianity.

It is certainly true that one cannot assert this with complete confidence. It can only be suggested as a hypothesis and with a great deal of caution. This hypothesis and caution should also be present when we try to identify how Christian morality gradually formed itself into a systematic body of doctrine, and when we try to assess the extent to which, if at all, the early Christian writers knew about Hippocrates. I am referring here to such authors as Tertullian (Carthage, 160?-240?), Ambrose (Treviri 340?-397), Jerome (Stridon 347 c.-420), Prudentius (Spain b. 348), Augustine (Tagaste 354-430), Isidore of Seville (Cartagena 560/570-636), the Venerable Bede (Wearmouth 672-735), Peter Abelard (Pallet 1079-1142), Bernard of Chiaravalle (Fontaines les Dijon 1091-1153), Hugo of St. Victor (1096-1141), Aelred of Rievaulx (Hexham 1109/10-1166/67), Raimondo Lull (Palma 1232/35-1315). All of these constantly cite Hippocrates in their works.

With the development of Christian morality the concept of "Christus Medicus" became almost a tradition, and to such an extent that in medieval medical manuscripts we at times find added to portraits of Hippocrates such expressions as "summus medicus est Christus."

The most important moment is when with the passing of time we find a meeting between the Hippocratic and the Christian ethical messages. This meeting appears at times to be an absorption by the second of the first, and although this is not always the case one could perhaps at times speak of an impact rather than an encounter.

But this does not detract anything from the authentic and fundamental questions to which His Holiness John Paul II pays repeated attention, questions relating to the "moral teaching of the Church (1993), the "value and inviolability of human life" (1995), and the relationship between "evangelization and inculturalization." This last question was dwelt upon and discussed in particular fashion at Yaoundé in Cameroon on September 14, 1995.

For this reason, the Christianized Hippocratic "Oaths" become especially significant and indicative, and in particular that taken from Ms. Ur. gr. 64 and used for the program of this international conference. Probably, as the Holy Father declared in 1994, "that illuminated amanuensis of the thirteenth century who wanted to transcribe the Hippocratic oath in the form of a cross already perceived in the rational argument about the right to life a value which was propaedeutic to the Christian concept of the human person, to the sacredness of life, indeed to the full recognition of the mystery of life. This recognition does not humble the impulse of science—it encourages it and renders it noble."

Professor BRUNO ZANOBIO
Professor of the History of Medicine and Pro-Chancellor of the University of Milan

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GONZALO HERRANZ RODRIGUEZ

Contemporary Ethical Codes of Professional Conduct

Introduction:
The Four Ethical Lessons in Professional Conduct Offered by the Good Samaritan

Let us imagine for a moment that the parable of the Good Samaritan were given to us as a case to study and to examine from the point of view of professional ethics. The idea, however, is by no means new. The parable was used by A. Jonsen as an exercise in clinical cases studies to demonstrate that there are inevitable limits to the possibilities and capacities of contemporary medicine. Let us leave aside the application of the parable to situations which belong to the realm of the purely fantastic, and introduce it instead into a seminar on medical ethics for students or for young professionals of medicine and nursing.

Let us read the parable and ask these young people to seek to identify the questions posed by the episode and to detect the lessons offered by the story in the light of ethical codes of professional conduct.

Their first discovery could be that the parable constitutes a paradigm for man's good and bad behavior—and in particular the good and bad behavior of the health care worker—when faced with a demanding and difficult situation. If one of the members of our seminar had a certain knowledge of general or professional law, he could add that the parable also comments on the behavior of the priest and the Levite—behavior which is, of course, so at odds with the exemplary conduct of the Good Samaritan. Such behavior constitutes an offense which is punishable by law in many countries of today's world—an offense rooted in a positive failure to provide help. We can thus observe that *the obligation to provide help in a situation of emergency is the first lesson of the parable of the Good Samaritan as far as professional ethics are concerned.* If a member of the seminar were a careful and keen reader of the Gospels and knew about the tense relationship which existed at the time of Jesus between Jews and Samaritans—two communities which greatly despised each other because of their profound religious and ethnic differences—he would be able to make a number of very opportune comments. He would say that we have before us a standard case of emergency aid. The parable is an eloquent defense of the overcoming of ancestral hatred and misunderstanding promoted by the Gospel message of love for one's neighbor. Professional ethics command health care workers to employ the same dedication and competence in serving all patients, whatever their condition or status may be: *the second lesson in matters relating to professional ethics which the Good Samaritan gives us is to avoid a policy of discrimination in our treatment of patients.*

Let us suppose that one of the students who is analyzing the case not only reads the Gospel text, but also dwells upon the instructions and the notes which are to be found at the foot of the page of his annotated text. He knows that the author of the passage is St. Luke, a medical doctor. That student could well grasp that the hagiographer Luke, while writing his book under the inspired influence of the Holy Spirit, would not have failed to continue at the same time to be a physician. For this reason St. Luke inevitably projected his personality into what he wrote, and also transferred himself as a physician into the figure of the Good Samaritan. Our students would be able to deduce, and rightly deduce, that the Good Samaritan was in reality a good doctor.

This is shown and borne out by what the Samaritan does: his human heart is moved by pity. He gets off his horse and, acting like a good professional, he proceeds to examine the wounds of the injured man. The Good Samaritan then assesses the clinical situation, takes out bandages, balsam, and wine from the bag he always carries with him, and provides first aid. He makes sure that the wounded man is in a condition to be moved, places him on his horse, and takes him to the nearest inn. The Samaritan settles him in the inn and looks after him for the entire day and perhaps for the night as well. The story of the Good Samaritan provides us with a *third lesson on the ethics of professional conduct: that of medical benevolence, the feeling of the medical doctor for the wounded man and for the sick man.*

Only on the next day, when the prognosis is favorable, does the Good Samaritan, after giving the innkeeper precise instructions about how the wounded man should be looked after and after handing him money to pay for immediate expenses, continue on his journey. He also promises the patient that he will return and pay him a visit and tells the innkeeper that he will later settle any future expenses. The Good Samaritan thus gives us a *fourth lesson: the selfless duty to serve the patient without payment and to help him in a generous way.*

My task this morning is to demonstrate the ways in which these four lessons of the Good Samaritan have found a place in modern ethical codes of professional medical conduct. It must be recognized at the outset that the mission to help people in situations of emergency, to not to engage in acts of discrimination, and to serve patients with loyalty, hold a pre-eminent position in the general and fundamental obligations which shape the overall actions and role of the health care worker. On the other hand, it should also be pointed out that the duties which require benevolent friendship and altruistic help occupy only a marginal position in contemporary ethical codes of medical professional conduct.

1. The Obligation to Give Treatment and Help in Situations of Emergency

The obligation to provide treatment and care in situations of emergency is present as a shared rule in all present-day ethical codes of medical professional conduct, even though, of course, this obligation is stressed in different ways and with different emphasis according to the countries or cultures which give rise to such codes.

In the codes of the Latin-Mediterranean region this duty is one of the general principles of the conduct of the medical doctor. For this reason the oath that the Italian doctor must take at the moment of enrolling himself in the profession includes the undertaking to "provide emergency help to any sick person who is in need of it." Article 7 of the Medical Deontological Code of Italy of 1995 declares as follows: "The doctor cannot refrain from acting and must provide help and emergency help to those who need it and always ensure the supply of any other kind of more specific or suitable help, quite independently of his usual specialization and in every kind of place and circumstance." The French, Spanish, Portuguese, and Belgian ethical codes echo the Italian code and insist on the inescapable duty of each medical doctor to provide immediate help to a wounded person or to a person who is seriously ill: these codes make clear that this duty is present because of the simple fact that an individual is a medical doctor and disregards what the specific professional role or specialist training of that individual might be.

In different and opposing fashion the rules of the Anglo-Saxon world are weaker and more vague. On the one hand, the ethical guidelines of the British Medical Association say that "in a case of emergency, it is hoped that all doctors will offer their help, but the extent to which they provide such help and the means that they employ will depend upon the nature of that emergency, the possibilities of obtaining more expert help, the nature of the threat to the life of the patient, and the readiness of the doctor to engage in actions which are beyond the range of his usual clinical experience." The Guide to Ethical Conduct of the Medical Council of Ireland confines itself to observing in vague terms that "the doctor must provide help in emergencies and must ensure that the patient has alternative forms of treatment and care available."

In the United States of America the fear of being subject to court cases or prosecution for malpractice in the provision of inadequate and inappropriate treatment to a wounded person or a sick person in the place where the emergency takes place, has had a marked influence on the attitudes and behavior of medical doctors in that country. Following the liberal-radical approach and style which prevails in the world of North American medicine, the *Principles of Medical Ethics of the American Medical Association* do not lay down that there is necessarily a duty to provide help in emergency cases. They observe, rather, that such cases constitute an exception to the right of the medical doctor to choose the patients he wants to treat. The Fourth Principle of Medical Ethics declares that: "In giving suitable attention to his patients the doctor is free to choose who he will treat except in situations of emergency."

It is precisely as a result of this weakness in matters of ethical duty in professional conduct that various states of the Union have passed laws which have been termed "Good Samaritan Laws." These laws lay down that medical doctors, nurses, and, in certain cases, ordinary people who have provided help in cases of emergency in places outside the hospital or the doctor's office and have not had suitable instruments at hand are not to be held responsible for their actions, in the sense of both commission and omission. It is surprising indeed that the Good Samaritan appears on the American health emergency scene because of legislative initiatives and not because of what ethical codes of professional conduct lay down. There are no specific professional rules or guidelines in the Jewish ethical tradition to govern emergency situations. But the Jewish tradition parallels the Christian tradition of believing that life is sacred, a tradition established and promoted by the Bible. It therefore upholds the prevalent duty to defend life, a duty which is enforced with such insistence that any legal norm which enters into conflict with this overriding commandment becomes subordinated and takes second place. The medical action of taking care of someone who is in danger of losing his life is sanctioned in such a way that the medical doctor does not have to do penance for having disobeyed such precepts as respect for the Sabbath day because he has come to the aid of a wounded or sick person.

I have not been able to come across any reference to the duty to help people in situations of emergency in the *Islamic Code of Medical Ethics.*

At an international level we should take note of the positions of the World Medical Association expressed in one of the clauses of the *International Code of Medical Ethics* (the London Code of 1949). This clause lays down that one of the duties of the medical doctor in relation to the patient is as follows: "the medical doctor, as a humanitarian duty, must provide help in cases of emergency unless that medical doctor is certain that other people are ready and able to provide such help." The framework of ethical codes of professional conduct in the sphere of medicine is completed by the guidelines and rules provided by certain associations of health care workers who are specialized in providing services in situations of emergency (that is, nurses, hospital doctors, and laboratory technicians). These norms declare that in every situation of emergency there is a duty to revere life, to respect the dignity, the autonomy, and the individuality which are inherent in every human being, and to refrain from compromising the trust of the patient.

It is not easy to draw valid conclusions from this survey of comparative deontology. However, it is possible to identify certain problems which should be examined and discussed, such as the possible relationship between the ethics of values and the ethics of rights to be found respectively in the Protestant and Catholic traditions, and the norms about emergency situations which prevail in those countries which belong to these traditions.

It would also be interesting to study and examine why over the last few decades the oldest, most competent and most experienced medical doctors have gradually transferred responsibility for the provision of help in cases of emergency to younger doctors. What, we may ask, has caused this historical change: the power of older doctors who live a life which is less stressed by the tension and the hours worked of medical emergencies, on the one hand, or the need to ensure that in the training of the young doctor there is a period of tension caused by the many pains of professional formation which will provide him with a suitable psychological, professional, and ethical maturity, on the other? Let us now pass to the second lesson which is offered to us by the parable of the Good Samaritan.

2. The Duty to Refrain from Discrimination and to Treat All People in the Same Way

The parable of the Good Samaritan amounts to a defense of the universality of medical service. Nobody is excluded from that service, neither the most hated enemies nor the most de-

spised neighbors, nor the victims of the most repugnant and repellent illnesses which can exist.

In this parable, as in many others to be found in the Gospels, Jesus wanted to engage in a certain exaggeration in order to give greater force to his teaching. He wanted to give his moral message that impetus and power which would overcome ancestral and long-standing prejudices and hatreds. We can see that for the Jews of his time it was an extreme exaggeration to seek to illustrate the commandment to love one's neighbor with a brief tale which involved charitable and self-sacrificing service between the members of two ethnic groups who had converted their mutual hatred into a fixed cultural form. The fact that the victim was a Jew and that his savior was a Samaritan constituted an apodictic argument in favor of the idea that there are no cultural, religious, or political factors or considerations which should place limits to the commandment to love one's neighbor, a commandment, it may be observed, of universal relevance and importance and of great intensity and power. In today's world this commandment has become highky relevant because medical doctors and nurses now have to deal with patients who are afflicted by the AIDS virus. The most eloquent expression of the duty of the medical doctor and the nurse to serve everyone in the same way is, in my opinion, to be found in the following statement: health care has only one professional ethic and this holds sway in periods of war and periods of peace alike. Thus it is that the first article of the *Ethical Principles of European Medicine*, which was promulgated by the International Conference of Medical Associations in 1987, reads as follows: "The vocation of the medical doctor involves protecting the mental and physical health of man and alleviating his suffering in full respect for the life and the dignity of the human person...both in times of peace and in times of war." The deontology of the two equally honorable ways by which the function of health care workers should be expressed in situations of war is thus more than evident. What are these two ways? On the one hand, there is the role of military medical doctors and nurses who have helped to humanize armed conflict through their dedication to wounded or ill soldiers or civilians. On the other hand, there is the role of those who have seen the enormous suffering and death that wars cause—in particular, in the civilian population—and have decided to declare themselves pacifists, to refuse to take part in the army, and to contribute—through humanitarian missions—to the reduction of the tremendous impact that wars have on human health and human rights. Both forms of service proclaim that there is only one set of ethics for the medical doctor in times of war and in times of peace.

From time immemorial there has existed within professional codes of medical conduct the glorious tradition of not engaging in discrimination: *I do not ask your race, your religion, or your origins. I am only interested in your illness.* We do not know the origins of this phrase but we do know that it belongs to the oral tradition of medicine. The first written exposition of the teachings of the principles of nondiscrimination in the practice of medicine seems to be found in the recommendation made by a Chinese doctor of the seventh century to his disciples: "Bring consolation to the suffering of every human being without worrying about his social rank, his economic means, his age, his beauty, his intelligence, whether he is Chinese or not, or whether he is a friend or an enemy."

Some months before the United Nations published the *Universal Declaration of Human Rights*, the World Medical Association decided on the inclusion within its *Geneva Declaration* of 1948 of the following promise by the medical doctor. This promise involved undertaking to "rise above political doctrines and religious beliefs, nationality, race, and social rank, and to keep such elements from acting as an obstructive barrier between my professional duties and my patient." In 1994 at Stockholm the Association decided to rewrite this clause in order to bring it up to date with these strange times of ours. The new clause reads as follows: "I will not allow considerations of age, illness, or incapacity, beliefs, ethnic origins, sex, nationality, political loyalty, race, sexual tendency or social level to act as an obstructive barrier between my professional duties and my patient."

This nondiscrimination clause has passed from the *Geneva Declaration* to all modern codes of professional conduct in medicine. For example, the French code of 1995 declares: "The medical doctor must listen, examine, advise and treat all people with the same conscience, whatever their origins, their customs, their family context, their membership or otherwise of an ethnic group, of a nation or of a specific religion, their handicap or state of health, their reputation or the feelings that the doctor may have towards them." The Good Samaritan did not investigate the history of the wounded man he came across. That man was certainly a Jew. But in essential terms above and beyond his nationality he was a seriously wounded man. The Good Samaritan inaugurated what would become the Christian tradition, and according to this tradition health care workers identify the sick, whoever they may be, with Jesus Christ. This tradition would and will last as long as there are sick people and will finish only when Christ says to all men of all times: "I was sick and you visited me; that which you did to them, you did to me."

3 Reflections on the Mission of Medical Benevolence

I am happy to say that the *Charter for Health Care Workers* of this Pontifical Council for Pastoral Assistance to Health Care Workers certainly belongs by right to contemporary ethical codes of professional conduct. Of all these codes, this *Charter* is the one which addresses itself with the greatest freedom and the greatest depth to the question of the concerned, caring, trusting, and open attitude and approach which health care workers should employ in their relationship with the individual and the needs of the patient. This *Charter* declares—in a language which has unfortunately long been absent from ethical codes of professional conduct—that "to treat a sick person with love is to engage in a divine mission—a mission which alone can motivate and sustain the most disinterested, helpful, and faithful involvement possible."

The modern codes of medical professional conduct have formalized the relationship between the medical doctor and the patient to an excessive degree. They have dealt with it in the light of a bureaucratic, legal, and contractual mentality. They have turned that relationship into a superficial and technical thing which in the hospital realities of today can become more than anonymous and faceless. They have abandoned what the old professional guides prescribed about the deontological range and limits of the proper emotional bond between the physician and the patient, about the friendship between them, and about the value of benevolence—all elements which are characteristic health care expressions of the Gospel commandment to engage in charity.

The ethical codes of professional conduct in Southern Europe contain, nonetheless, many elements relating to the value of medical friendship. The *Code of Ethics and Medical Deontology* which is presently in force in

Spain includes on its list of doctors' ethical duties towards their patients that of making sure that their work expresses a sense of service which should be provided with delicate respect, with concern, and with loyalty. This service, according to this Spanish code, should be placed before any question of personal convenience and should take precedence over any unjustified delay in attending to the needs of the patient. The *Spanish Deontological Code for Nurses* adds another duty to these duties—that of protecting the patient from every form of humiliating or degrading treatment and from any form of treatment which injures or wounds his personal dignity. This code also insists that moral or physical force should never be used against the patient. The duties of the nurse become more detailed and incumbent when the patient belongs to a vulnerable group—that is, invalids, the handicapped, children, and elderly people, to whom, indeed, special and qualified attention should be given.

It is clear that a large part of the attention that doctors and nurses pay to their patients cannot be effected without strong echoes of the actions of the Good Samaritan—without, that is, an inner readiness for caring dedication which is expressed externally in the suitable and delicate way in which professional services are rendered. It has been said over and over again that to serve is to love. Perhaps this explains why today's codes of professional conduct speak about service and never about love. Such contemporary codes are very hesitant about dealing with the emotional ties which can rightly become established between health care workers and their patients. They deal with this subject with the serious and grave tones of the Hippocratic Oath so as to ensure that the doctor and the nurse do not go beyond the limits imposed by professional prudence and which are required by the promotion of equanimity in the health care field. Great emphasis should be laid upon the deontological duty of the doctor to avoid becoming emotionally involved in a professional relationship. The health care worker must keep a suitable emotional distance from the patient and thus must not go beyond what William Osler calls "courteous love" for the patient. It should be observed that the sentimental or frivolous neglect of this rule has caused a great many difficulties and problems in the world of health care.

Indeed, nothing is more destructive of a relationship between a medical doctor or nurse and the patient than falling prey to the temptation of excess in intimacy, of romantic curiosity, of flirting, or of engaging in sexual relationships. The *Code of Medical Ethics* of the Council of Medical and Judicial Affairs of the American Medical Association makes clear that "sexual relationships between doctors and patients degrade the goals of medicine, exploit the vulnerability of the patient, obscure the objectivity of the judgment of doctors in relation to the treatment they should provide, and, finally, prejudice the well-being of the patient.... At the very least, the ethical duty of doctors requires that their professional relationship with their own patients be ended before they begin any kind of personal relationship with those patients (going out together, romantic love, or sexual relations).

We now come to the fourth and last lesson which is offered to us by the famous parable of the Good Samaritan.

4. The Selfless Duty to Serve Patients without Receiving Anything in Exchange, Indeed, the Duty to Help Them in Generous Fashion

This tradition has disappeared from the ethical codes of professional conduct which are applied to national health systems which offer free health care to all citizens. But this is not the case in those countries where a large part of the population has to endure both economic poverty and a marked lack of health care. This is tragically the case in poor countries, but it is to a certain extent also present in the United States of America, where between thirty-five and forty million human beings do not have the means by which to obtain suitable health care.

Indeed, in the United States of America the tradition of benevolent care for the poor patient is still very much alive. The *Code of Medical Ethics* of the American Medical Association says that "all medical doctors are obliged to help in providing medical help to the poor...and to work to ensure that the needs of the poor of their community are met. Taking care of the poor must be an ordinary part of the ordinary program of work of the medical doctor.... This can be done in a host of different ways: by receiving patients at the doctor's office without asking for fees or asking for reduced fees, through providing free service in hospitals and clinics, through taking part in government programs which offer medical care to the poor, and through providing service in charitable medical facilities or in shelters and homes for evacuees or ill-treated women." In the codes of the countries of the European Union we have left to us only so-called "professional courtesy" as a residue of this old charitable tradition. This professional courtesy involves a medical doctor treating a colleague or the relative of a colleague without asking for the payment of fees out of a sense of friendship and as a moral reward for the trust that is reposed in him.

As we know, the relationship between doctors and money is very complicated and intricate in character. This relationship has been represented by triumphant Aesculapius, who appears as an angel when he attends to the patient, as a god when he cures him, and as a devil when he asks for the payment of his professional fee.

Conclusion

The parable of the Good Samaritan enormously enriched the precepts of the Hippocratic Oath. This is because in addition to the duties of scientific competence and respect for the human dignity of the patient which are incumbent upon the disciple of Hippocrates, the parable also requires the health care worker to rise to the supreme duty of charity altruism, self-denial, nondiscrimination, and generosity. These duties, whether selfless or not, fortunately enough have been incorporated into the ethical codes of professional conduct which are presently operative in today's world, or have taken the form of uncoded obligations which act upon the soul of health care workers. The famous Oath and the parable of the Good Samaritan have exercised, and continue to exercise, a synergetic influence on the ethical codes of professional conduct in the health care field. May the permanent memory of the fascinating figure of that physician, the Good Samaritan, inspire our professional conduct and behavior. I will conclude by quoting the words of the Holy Father, John Paul II, which are to be found in the encyclical *Salvifici Doloris:* the health care worker is the Good Samaritan of the parable who draws near to the wounded man and makes him his neighbor in charity.

Professor GONZALO HERRANZ RODRIGUEZ
Member of the Executive Council of the Pontifical Council for Life, Director of the Institute of Bioethics at the Catholic University of Navarra, Spain

CARLO CREMONA

Care for the Sick and the Fathers of the Church

1. Whence Evil

The subject of this paper leads us to think about events which are very far-away, where our memory and human history do not reach. And the tale which comes to us, in addition to the innate drama of every man, is of a religious or mythological character. By natural instinct man seeks stable and integrated happiness, he continues to hope for it. But despite this innate vocation, this divine dream, he is that being on the earth which can suffer both physically and spiritually. The reconciliation of these two real and practical tendencies, the need for happiness and its denial, is the permanent drama of man.

Those who profess a faith in an absolute Being in their way of thinking about existence, a Being who is transcendent, infinitely perfect, the sole cause of the universe and of all created things, can but ask themselves about a fundamental question when they are faced with pain. This question relates to the great difficulty we face in crossing a frontier to enter into an area of a metaphysical and mysterious character which touches the responsibility of God: *"where does the evil come from of which man, contradicted by an instinct to happiness, is the principal victim? And yet, in actual fact, the finger which made him offers all the guarantees we could need!"*

I would like to know how to translate into two Michelangelo-style frescoes that description of the world and of man (who is its principal and most responsible tenant) which St. Augustine makes in the *City of God*, a distinction between beauty and horror of the world of which man is the subject.

The world (where our life takes place!) when observed from the point of view of the mineral, vegetable, animal and spiritual worlds, is in itself an enchanting harmony and beauty. And man should have enjoyed his friendship with God in tranquillity, until the point when he was by his own wish received into his celestial homeland.

St. Augustine speaks in the following way about the human body:

"So great is the rational beauty of the human body, and even of the lower and less noble parts, that they are considered pleasant and superior to any other visible form according to the judgment of the spirit of the eyes which are used. In painstaking fashion certain physicians called anatomists, moved by the harmony of the human body, have dissected its limbs to see if such limbs are made for a function or for beauty. None of these parts has a useful function without at the same time having its own beauty."

St. Augustine concludes by referring to the wonders of the human mind, its technological achievements (even during his own times), and its artistic production in the sphere of literature, in sculpture and painting. "A day will come." he asserts, "when we will enjoy each other"s beauty alone."(*City of God*, XXII, 24, 22).

But such beauty and the enjoyment of such beauty is in permanent contrast with the historical reality which man, above all other creatures, perceives and suffers. The contradiction between the beauty which informs the creation, which is given for man's enjoyment, and the pollution in which man is immersed, is very striking. Man is both the compelled creator of this contradiction and its victim. However much we may be materialists, we cannot accept the idea of being mere toys which are breaking up.

"Res sacra miser!" exclaimed Seneca: he who suffers in body or soul is a sacred being. That is to say, he is worthy of respect, pity, and solidarity.

Whence evil?

It is difficult to answer this question, and it has proved an impassable obstacle for many spirits. And not only for the spirit of St. Augustine who for many years embraced the Manichean doctrine, an approach which perceives two princes locked in struggle: the prince of good and the prince of evil, light and darkness, the spirit and matter. Desperate in his search for the truth, he ended up by concluding that if one begins with the experience of evil in the world, one finishes by being pessimistic or skeptical.

If God is infinite goodness, an ocean in which everybody is born and everybody is enveloped, and if the created being is immersed in that ocean like a sponge, then why—St. Augustine pondered—is this sponge so infused with pollution? Where did it absorb it from? At the outset he drew near to the bible (the sin of free man against God the creator, rebellion of his liberty to be master of an independent happiness without God); rationalism, pride; lack of humility and reasonableness; rejection of the supernatural and of grace—all of these elements led him to perceive the bible as a collection of tales of little literary merit!

At a very young age he abandoned the Christian faith of his mother Monica.

The recovery of these values was a very arduous process for St. Augustine. It was the outcome of reading the works of non-Christian philosophers: Cicero (who in one of his works demonstrated the emptiness of earthly values and proposed spiritual values which were immutable

and transcendental); Plotinus who followed Plato in demonstrating the spirituality, the absolute, and the infinite goodness of God. Plotinus explained evil not as a substance but as the absence of substance, and in more specific terms a wrongful lack of the presence of God (Conf. VII, 10, 16, *"And I saw a light..."*).

He then read the works of Ambrose who was at first read out of a sense of literary taste and because of his Latin eloquence which made him a kind of second Cicero. St. Augustine then read him because of a deep interest in his biblical preaching. He then went on to the letters of St. Paul. The letter to the Romans (pain and death have entered the world through the sin of free man) was suggested to him by the mysterious voice of youth *("Take it and read it")* and provoked in him the experience of being thunderstruck by grace. It also produced his immediate conversion to Christianity in the house of his garden in Milan.

As I said previously, the intense and difficult path taken by St. Augustine was the path trodden by many spirits, including those who were intellectually and morally chosen. But it was also, I might observe, the path taken by each one of us.

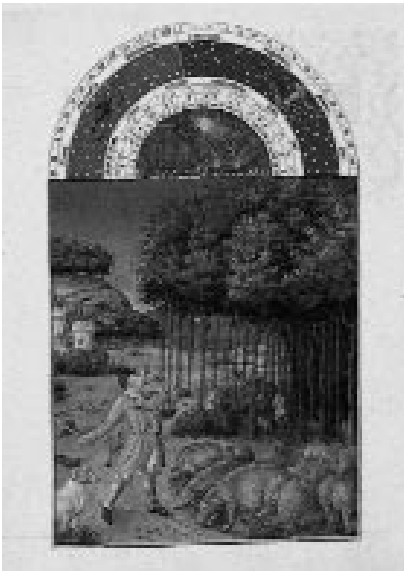
That initial rebellion which was a very serious act of personal wrongdoing by those who carried it out was a test. It was a way of seeing whether the free will of man would accept the supremacy of a personal and liberal God, his free gift. It was a test to see if man would remain forever on the side of God. That rebellion is bequeathed to human descendants like a void, a pathological inheritance, a lost wealth which cannot be regained and which has left a deep wound within the whole organism. In this process it has generated pride, ignorance, superficiality, and a lack of care in inquiring into the distant and real cause of impoverishment and unhappiness. If man is the created being of God he could but be created in happiness and for happiness.

Thus it is that it necessary to make a diagnosis of this original evil, as one does for every evil. That is to say through philosophical inquiry, through the acceptance of the instruction of supernatural revelation. (Plato and human navigation: the sail, the oar... *"unless one has a safer means of transport which is divine revelation."* Cf. Phaidon 85A/86B).

That the radical evil suffered by man is the fault of initial pride is not a doctrine of the bible alone where there is indeed a description of our mysterious condition. It belongs to all cultures, to all religions, and to all mythologies. In the autumn of the year 385 AD St. Augustine decided to read the Holy Scriptures for a second time, texts which he had deemed unworthy of his literary aesthetics.

He was obliged to do this because of a moral and religious crisis, and he engaged in his task with humility. He proceeded to define the bible as a masterpiece of instruction and a picture-gallery with a poor entrance. But to cross the threshold—what artistic splendor!

Genesis describes the prohibition



about eating the fruit of the tree of good and evil. Adam, with Eve, disobeyed.

St. Paul comments: *because of the sin of one person, disorder, evils and death entered the world....*

There is a law in my flesh which is in opposition to the law of my spirit. As a result I do not do what I would like to do, but what I would not like to do.... Poor me! Who can free me from this body of death?

The reply he received was:

Grace! My grace should be enough for you.

Man was created in grace.

Supernatural and sanctifying grace is friendship with God.

But friendship of a kind which creates a loving intimacy, a sharing of nature.

He had to be confirmed by a test: so that man, created in the image and likeness of God, with a free will which could choose and a limpid intelligence in order to choose well, could become the stable master of his happy condition, together with God.

However he deceived himself into thinking that he could be happy without God. He lost the wager, the dignity of a friend, and fell...

And he did not only lose grace, but also other things as well.

For example, *integrity:* harmony between the intelligible and that which could be reached with the senses, between the senses and the will...Whence the inner contradiction of every man: *law of the flesh against the will of the spirit* (St. Paul).

He lost the physical *immortality* of his corporeal life: (our body, a building built with matter which by its very nature is destined to destroy itself...). Dear friends, if we do not convince ourselves of the truth of this diagnosis, if we do not begin again from these truths, from this distant but always radiant revelation, we will not be able to understand anything about life: darkness will fall! And today mankind walks in the dark: rejection of the supernatural, and of grace. Self-sufficiency!

We have to care for both souls and bodies. Given what happens in the world, because of a lack of moral values, we doubt at times that there is a will to even care for bodies: ill health! The substance of the bible tale is neither Judaism nor Christianity; it is not denominationalism.

It is truth which forces even pagans to ask themselves:

Video meliora proboque, deteriora sequor (Ovid)

Veggio il meglio ed al peggior mi appiglio (Petrarch)

Here we encounter the same thesis to be found in the Bible and in St. Paul. Sin: the source of the river of our moral evil and even of physical pain and the illnesses of the body.

Death entered with pain and was a protagonist.

"The immense corruption with which we were inundated because of this transgression, the agitation of many strong and contrasting sentiments, should not make us think that this was a small and slight moral act..." (*City of God,* 1. 14, c. 12).

2. Redemption in the Incarnation

But it was precisely from this abyss that Christian rebirth and opti-

mism were born. It should have been an irreversible process.

But God accepted the challenge of man and revenged himself with an event of mercy, an event which was greater than the creation of the universe, even if risky.

God so loved the world that he gave his only—begotten Son for the salvation of the world.

The mystery of faith which, whether recognized or not, links man to God, even when man rebels and flees from God. It offers us the mystery of the incarnation of the Son of God, who takes on human nature, takes on himself our sins and our pains, and accepts death to achieve the redemption of man. Paradoxical!

Where sin abounds, grace abounds even more.

The incarnation of Christ, the Word of God, is a disturbing dogma which is acceptable because of an explicit and insistent revelation of God, begun by, and intimately linked to, the sin of man.

Why disturbing?

Because human reason (see Plato, see Aristotle) manages to know the nature of God, who is spiritual, unchanging, absolute, transcendent, infinitely good and the source of being.... It manages to discover even the Word of God.

But if I were to say to Plato: *That God to whom you refer and whom you define as being the* ***highest good of man,*** *I met on the roads of Palestine. I saw him suffer and die for the salvation of man. He rose again after death and he guides us to eternal life, in both body and soul."*

If I said that, Plato would laugh in my face as if I were pronouncing some philosophical heresy. The absolute cannot become contingent, the eternal cannot become temporal. The spiritual by its very essence, the pure act, cannot become corporeal and of the senses.... The incarnation, the most ineffable doctrine of Christianity but at the same time the most difficult, opens the human intellect like a window so that the solar light of the intimacy of God can be received. *"Believe to reason; reason to think."*

The dogma of the incarnation has so much importance for humanity that it cannot be confined to a mere religious creed: it has universal value.

The person of the Word, who remains of divine nature, not only unites himself in history to human nature, but also shares its humiliation, its physical and moral pain, and its death, and all this in a dimension which is the highest expression of all the humiliations, all the pain, and all the deaths in the history of mankind.

3. Christ, the Man of Pain

Isaiah: Servant of Yahweh (Is Ch. 42-53).

The Agony of Christ in Gethsemane: the universal human tragedy in its ***first three-dimensional expression;*** from Adam, to Abel, and...to the death-rattle of the last man.

The outflowing of blood, a phenomenon which doctors call

"haematridosis," something which is connected to a major disturbance of the nervous system: *"Sad is my soul, until the moment of dying."*

From the moment of his birth, Christ wishes only to die for love of man: "I must receive baptism, and I will be troubled until I receive it."

4. Care for the Sick and the Fathers of the Church

The Fathers of the Church were an expression of the continuity and the authentic interpretation of the message of Christ and the doctrine of the Church.

They were men of holiness and great intelligence.

They were great philosophers who renewed and rewrote the thought of the Greek philosophers of the pre-Christian era. They were great theologians and profound experts in the language of God and in matters relating to the ancient civilizations of mankind.

And it is here that we come to the subject of this paper.

Care for the sick. This was a major aspect of the Redemption but was of apparently secondary importance—bodies are healed, but God is interested in souls. But man is an integral *"unum"* when taken as a whole. If you cannot love man, whom you can see, how can you love God whom you cannot see? This is not therefore a secondary aspect; it is at the very least *"aeque principalis."* The love of God is for the whole man, and in its corporeal and spiritual value cannot be divided into two. It is a love which is freely given and not won, and which restores the mutual friendship between man and God, and between man and man. It is a new right to a life of infinite happiness which is shared with God himself. God is man's loyal friend: *"animae dimidium meas!" Who is my neighbor?* The vicar of God!

Christian redemption gave us the mother Church, teacher and expert in humanity. How could mankind ignore the Church of Christ even if—while knowing that she was present and working—it neglects her, turns its back on her, and listens to other teachers?

The redemption gave us priesthood (that of every ministry and every baptism). It gave us grace which is more abundant than original grace, even though in the new order we have become the objects of pain, of illness, of death and of the struggle for good.

And here everything changes:

Pain and death are no longer punishments. They are reasons for expiation, of merit (think of the suffering of those who are innocent!). They become an asset (in relation to Christ something which is *completely given;* in relation to man, a question of *participation*).

The phrase of St. Paul is very beautiful (with my suffering *"I complete what is lacking in Christ's afflictions, in the Church, in me"* (Col 1: 24).

There is another miracle: pain (both physical and moral) can become the source of great joy. *"I am overflowing with joy in every trial.... The sufferings of this world bear no comparison to the future glory which awaits us."* (St. Paul)

The cross, that sign of ignominy, becomes an instrument of triumph.

"He who does not take up his cross every day to follow me, will not be recognized by me."

Care for the sick and for physical misfortune—a visible sign of the Messiah: *"Go and tell John: the blind see, the deaf hear, the dumb speak, the lame walk, the lepers are clean; and to the poor is proclaimed the Good News."*

Charity, love, solidarity! Without barriers, even towards the enemy. The Good Samaritan...who stops at the side of the wounded man, who cares for him and places him on his pack animal (the ambulance of those times), and then takes him to an inn to get better, paying for him with his own money. This inn is the first "Hotel-Dieu," as hospitals are called in France!

5. Church-Fathers-the Sick

Christ created the Church and was its corner stone. For twenty centuries she has watched over mankind and guided humanity with her divinely guaranteed Magisterium. Some Sundays ago John Paul II referred to the thirty years of the life of the Council's Constitution *Gaudium Spes*. He declared that it tackles "the problems of the contemporary age: marriage and the family, culture, socioeconomic reality, politics, the promotion of peace and solidarity between peoples."

Christ...spouse...without blemish or wrinkle...The mystic and visible body of Christ down the centuries ("Total-Christ...").

The root is him, the good tree cannot produce bad fruit. "Rooted in charity and founded on charity." In the Church, as in a mine, there is the golden vein of charity.

Immediately after being born there is nothing but continuity between the work of Christ and the emergent Church:

The Church seeks to welcome the sick as Christ had done:

"They carried the sick (to Peter) *to be healed by his shadow alone."*

The Eucharist: "the sacrament of pity, a sign of unity, or a bond of charity!" To the sick: heal, soothe, comfort... (Justinian).

Apostolic Church and the preaching of the suffering Christ.

Peter: *"Resist him, firm in your faith, knowing that the same experience of suffering is required of your brotherhood throughout the world."* (1 Pt 5:9) ***Solidarity!***

"And being found in human form he humbled himself and became obedient unto death, even death on a cross." (Ph 2:8).

"Having cancelled the bond which stood against us with its legal demands; this he set aside, nailing it to the cross." (Col 2:14).

"But far be it from me to glory except in the cross of our Lord Jesus Christ" (Gal 2:14).

"For I decided to know nothing among you except Jesus Christ and him crucified." (1 Cor 2:2).

"And those who belong to Christ Jesus have crucified the flesh with its passions and desires." (Gal 5:24; 1 Cor 1:13).

"But we preach Christ crucified, a stumbling block to Jews and a folly to gentiles" (1 Cor 1:23).

The funds raised by Paul from the churches in Asia for the impoverished Church in Jerusalem.

The Church and her apostles, true to the teaching of their Master, are concerned with both souls and bodies, and in equal measure.

In unique fashion the Christian religion promises that the body, as well as the soul, will have eternal life.

Before Christ there was Stoicism: *"substine et abstine"*...Resistance to pain.

Christ gives us the ability to overcome suffering and to smile: St. Francis and the cure of eyes with red-hot tears...And then the sick woman in an iron lung: *"My special Ferrari with a red head"*.

How many people have resisted the violence of pain by looking at the Cross in order to be like it.

Chataubriand (evil breeds of Christianity, *passim*).

Christian charity which separates Christians from other men, something which was unknown to the ancients, was born with Jesus Christ. In his gospel it was the emblem of the renewal of human nature.

The first Christians shared their goods in order to help the needy, the sick, and pilgrims.

It was in this way that hospitals were born!

From that moment, works of mercy no longer had barriers in their way. It was as if compassion overflowed into misery to the point of neglecting it and running after it: so much misery but an equal amount of compassion.

Here we ask: how did the ancients manage without places to go when ill, without hospitals?

In order to rid themselves of the poor and the unhappy they had two solutions which Christianity did not recognize: infanticide and slavery! Are the ruins of hospitals or hospices to be found amongst the ancient monuments of Rome or of Athens?

Some local hot baths dedicated to some divinity had the mere appearance of a health care structure, like Hepidaurus.

(Lucretius: *"Mussabat tacito medicina pavore"* (the plague of Athens).

(Martial: *"I was rather ill. I called the physician, Heliodorus, who arrived with a band of his disciples: forty cold hands pressed my stomach. I did not have a temperature—I do now!"*)

As the Church gradually acquired freedom of action (the apostolic period, great monks, and then the great Fathers of the East and the West) hospitals, leper colonies and isolation hospitals (this last in Latin being derived from the name of poor Lazarus from the Gospel parable) sprang up.

In these institutions monks or mere Christians engaged in volunteer work with joy. Without any repugnance at all they bore the presence of all forms of human misery in order to serve Christ in person within their sick brethren.

"I was sick and you came to me, helped me, and took care of me."

Some Examples

St. Basil created a hospital-town

in the environs of Cappadocia. They called it "Basiliade".

John Chrysostom, the great Christian orator who was also called the "panegyrist of alms" was exiled by the Empress Eudoxia. He had denounced her publicly for having wrongfully gained the vineyard of a widow which had been destined for a hospital for the poor which he administered. The protector and the defender of the poor, he was consoled by their defense when he was persecuted by the powerful. Helping the sick gave John Chrysostom the chance to get to know doctors and to observe their humanity in their care for the terminally ill (the sick person has a fragile psychology which is in need of help, and the slightest thing can depress his spirits).

He describes how a sick alcoholic was desperate for a mouthful of wine. The understanding doctor made a small earthenware jug out of clay impregnated with wine. He filled it with water and heated it on a stove. He pulled down the blinds of the window to darken the room and took the jug to the sick man. The alcoholic was deceived by the smell of wine and drank the mixture with satisfaction. Chrysostom praised the sensitivity of the physician.

St. Jerome in letter number LXXVII to Oceanus gave great praise to a certain Fabiola, a woman who was the subject of much gossip but was a convert to Christianity. Fabiola had paid for the creation of a hospital for the poor.

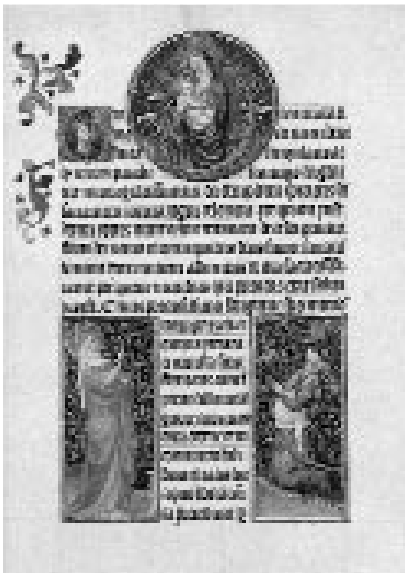
"She was the first person to establish a hospital for all the sick people she found in the street: deformed noses, empty eye sockets, withered arms and legs, extended stomachs, skeletal thighs, rotten flesh full of worms.... How many times did she herself carry those suffering from leprosy to the hospital on her shoulders...She fed them with her own hands and gave a spoonful of broth to those living corpses" (Letter number LXXVII).

Augustine of Hippo, according to his biographer Possidius, only went to homes where there were orphans and the sick. In the rules of the monastic order he established there is a special chapter relating to caring for the sick. He presents Jesus as the great physician of humanity who does not write a prescription for the chemist *but creates the medicine with his own blood,* in the exercise of his Humanity. "*Come to me all you who are heavy laden and I will give you rest."*

He gave a fine sermon on the transfiguration of Christ where Peter said: *"It is well that we are here; let us make three booths, one for you and one for Moses and Elijah*" (Cf Mk 9:4; Mt 17:4).

The Holy Doctor said: *"But come down Peter.... Yes, it is well! But not now. Come down, there are poor people to help, sick people to care for, the gospel to preach and to bear witness to.... Come down immediately; the vision will come afterwards."*

There was a similar statement when Marta was in the kitchen preparing lunch for the guest and her sister Maria was in the living room



enchanted by the voice of Jesus.

This episode gave rise to the dispute about the relative supremacy of the value of the contemplative life or the active life. St. Augustine provided the answer to the debate with one of his usual general summaries:
—*Caritas Veritatis* ('love for contemplation')—Mary;
—*Necessitas Caritatis* ('emergency action')—Martha. This emergency action is of primary importance in certain circumstances because of the needs of one"s neighbor: poverty, hunger, or illness. This is an action which is: *Delectatio Caritatis et Veritatis* (joy in loving God in one's neighbor, recognizing Him and contemplating Him).

"In caritate fundati et radicati!" The root of this charity is truly vigorous, for it has animated the Church and inspired important figures for two thousand years. These figures are: Camillus de Lellis, John of God, Cottolengus, Orion Guanella, Giovanna Antida. In our times we can think of Padre Pio, Follereau...and thousands of others, everywhere, missionaries in the leper colonies.

But let us not speak only of the past. Let us speak also of the present, of those who are alive today. Mother Theresa, and many, many others ignored amidst the fire of warriors.

This is what the official world knows how to do: not to love but to kill!

All the good of which man is capable is the exclusive gift of God. Outside this there is only misery and sin.

And yet the created being has a positive value which God does not have—suffering!

God envied man this condition and took it upon himself by being a victim of suffering.

St. Paul says, *"Not only man, but the whole of creation is waiting for the moment of birth."*

And St. Peter says, *"There will be new heavens and a new earth."*

St. Augustine, echoing Plato's invocation of a safe means (a divine revelation) by which to reach the shore of happiness, suggested its character: *"So that there could be a means by which to go, he to whom we wanted to go came from the beyond. And what did he do? He prepared the wood with which we could cross the sea. Nobody can cross the sea of this age without being carried by the* ***cross of Christ****"* (Com. Jn. Tr. 2, 2).

On one occasion Jesus asked:

"When the Son of Man returns, will he still find faith on earth?"

Perhaps we can reassure him:

"Faith, Lord? Who knows?"

"Hope! We believe in the capacities of men but they always make us lose hope."

"But charity, no. There will not be less charity. Because you, suffering and living with us, are charity. You, who promised to be with us until the end of time."

"Fides, spes, caritas: tria haec!
Maior autem horum: ***Charitas!****"* (1 Co 3:3).

FAITH belongs to man....
HOPE? Also!
CHARITY belongs to God....
It is not ***biodegradable!***

Rev. CARLO CREMONA
Vatican Correspondent for Italian RAI TV

GOTTFRIED ROTH

Hippocrates in the Documents of the Church and in Works of Theology

This paper is a survey of Hippocrates and the presence of his principal clinical-medical, philosophical-medical, and ethical ideas and beliefs in the documents of the Church and in works of theology. It therefore carries on from the study already conducted into references to Hippocrates in papal documents, works which have already been published.[1, 2] In this paper I will dwell upon those passages in the speeches and addresses of popes Pius XII, Paul VI, John Paul I and John Paul II which emphasize the ethical importance of this famous physician of ancient Greece.

This collection of quotations and citations is not an exercise in medical history which aims at creating a collection of documents. Nor is it an attempt to engage in a kind of literary history. It is, rather, a collection of ethical observations and guidelines which are to be found in surviving ancient Greek texts and which correspond in certain ways and forms with Christian ideas and beliefs.

We can safely state that during the great periods of the history of Western civilization there have always been examples of the influence of the ideas and ethical principles of Hippocrates.

At the time of early Christianity, the essentially Christian basis and character of central Hellenic ideas was demonstrated by the fact that in the preamble to the Hippocratic oath the introductory words "Apollo soter" came to be replaced by the phrase "Christus medicus."

The doctrine of Hippocrates could easily be transplanted into the patristic and scholastic traditions because it well corresponded to the integral and personalist ideas of Christianity and because of the authority of "Christus medicus," the phrase the doctor employed to swear to uphold the ethics of the medical profession.

This broad-ranging subject can only be dealt with here by analyzing key moments. Indeed, the research which lies behind this paper perhaps indicates that an overall and general picture may well not be possible.

There are also various other questions which must be addressed, and most specifically the actual authenticity of the ideas which are propounded in the works attributed to Hippocrates and of the texts which constitute the *Corpus.*

1. Hippocrates in Papal Documents

In the works of Petrus Hispanus, a medical doctor with academic qualifications who then became the doctor to Pope John XXI, we can find two comments on Hippocrates[3] namely *De Regimine Auctorum* and *Prognostica*.

In our times, and more precisely in 1954, Pope Pius XII defined the medical-ethical significance and meaning of the works of Hippocrates in the following way:

"The works of Hippocrates are without doubt the noblest expression of a professional conscience which above all else calls for respect for life and self-sacrifice in relation to sick people and also pays attention to personal factors: self- control, dignity, reserve. He knew how to present moral norms and to integrate them into a broad and harmonious program of study, and he thus gave a present to civilization which was more even more magnificent than that made by those who built empires."[4]

Pope Paul VI had similar observations to make and sought to warn doctors about the dangers which were inherent in the advances in medical science:

"It is clear that these new inventions should not in any way prejudice the exercise of a medical ideal which has guided medicine for millennia and has been expressed in a tradition based the oath of Hippocrates, a figure who was a defender of life. A pollution of this cardinal principle would involve a fatal step backwards which would have disastrous consequences. This is something which you will be aware of more than any other category."[5]

Under the title of "The Illustrious," Pope John Paul I wrote a number of imaginary letters to important historical figures, one of whom was Hippocrates—" a contemporary of Socrates and like him a philosopher." Pope John Paul I called the Greek physician:

"The author of a famous oath...of an ethical code of unending worth. Doctors swear by this oath to prescribe suitable treatment for their patients and to protect them from injustice and above all else from what is harmful. They solemnly promise to never induce an abortion; they undertake to go to a home solely in order to treat sick people and promise that they will not take bribes. In addition, they swear to uphold the sacredness of the professional secret."[6]

With this list of ethical-medical undertakings and promises Pope John Paul I blessed the incorporation of the ancient Greek code of professional conduct into the outlook and approach of the Christian medical doctor.

As early as 1978 John Paul II referred to Hippocratic ethics during a reception for the Association of Italian Catholic Doctors. He warned those present against the dangers of using medicines and drugs which "not only contradict Christian ethics

but every form of natural ethics and which are in open contradiction with those professional duties expressed in the famous oath of the ancient pagan doctor."[7]

In his address to the members of the General Assembly of the World Union of Doctors John Paul II, when discussing the question of genetic engineering and its capacity to reduce the human being to an object, proffered the following injunction: "Let all medical doctors be faithful to the Hippocratic oath which they take when they graduate."[8] During his speech to the members of the International Congress on the Humanization of Medicine held in 1987 John Paul II spoke about the need for men to be aware of their true duties in the exercise of their profession: "You should be deeply convinced of this truth because of a long tradition which goes back to the intuitions of Hippocrates himself."[9] And when nominating the members of the Pontifical Academy for Life John Paul II made an explicit reference to Hippocrates when he spoke about the need to "carry on the Hippocratic tradition."[10]

On November 26, 1994 Pope John Paul II referred again to Hippocrates when he spoke about a Vatican codex which contains the Hippocratic oath transcribed in the form of a cross, the symbol of the Christian understanding of human nature, of holiness, and of the mystery of human life.[11]

Under the unifying influence of the model of *Christus medicus*, Hellenistic naturalism and Semitic personalism were fused together in early Christianity, and this was a direct result of a new diagnostic approach to the origins and causes of illness. Without doubt it is to Hippocratic thought that we must attribute the move towards a sense of ethical responsibility which in turn gave rise to the creation of medical oaths which had preambles with a monotheistic character and conclusions with explicit reference to a transcendental reality, to God, before whom such oaths was sworn.[13]

2. Hippocrates in the Patristic and Scholastic Traditions

During the patristic age there was an abundance of quotations from the authentic works of Hippocrates and from the *Corpus*, and these have survived to us. Indeed, Cyprian of Carthage, Gregory Nazianzen, Gregory of Nyssa, and Eusebius of Cesarea all held to a theory of the natural sciences about the origins and causes of illness which went back to Hippocrates. However there were also magical and demoniacal theories.

It should also be observed that Eusebius makes repeated reference to Hippocrates in a chapter on the theory of illness, in reflection upon free will, and knew the ancient Greek's theory of diet. He was also familiar with the motto: "nature is the best physician." Eusebius also invokes Hippocrates when stressing the importance of prognosis and in expounding the idea that the soul is of primary importance in the relationship between the body and the soul. (14, 15) In discussing the Patristic tradition reference should also be made to the ethical-medical chapters of the Didaché of the first century after Christ: you must not induce the abortion of a child and you must not kill a newly-born baby.[16]

Research into Hildegard of Bingen (1098-1179) has drawn a blank as far as references to Hippocrates are concerned. Heinrich Schipperges writes:

"Hildegard of Bingen does not offer an explicit theory in this matter. He does not repeat the oath of Hippocrates and he does not speak about medical ethics. We do not find direct references to the goals of health care and no methods are offered in relation to caring for the sick person. There is nothing which offers instruction and nothing of a dogmatic character which could give rise to a theory on duties and their categorization. However his works are a contribution to Medieval deontology and are all the more valuable because such works were absent at the time. But because they are often not presented in a serious way they cannot be considered seriously."[17]

Honorius Augustodunensis, who died after 1150, wrote the following of Hippocrates: *"per medelam corporum deducit ad medelam animarum."* [18]

Knowledge about Hippocrates and about the *Corpus* was kept and handed down by Nestorian-Syrian Christianity. This branch of Christianity dedicated space in its schools and monasteries to the conservation and transmission of philosophical and scientific learning, and gave especial room to the Aristotelian part of this inheritance: not only Aristotle himself but also Euclides, Hippocrates, Galenus and Archimedes. The philosophical, mathematical and medical works of these authors were first translated from Greek into Syriac and then into Arabic.[19] The concept of *"potentia"* can be attributed to the Greek concept of *"dynamis"* which is also to be found in the *Corpus Hippocraticum* where it is used with reference to illness.[20]

The recent computer work on the writings of Thomas Aquinas gives us greater confidence and security in relation to our subject. In discussing the meteorology of Aristotle, Aquinas makes a number of references to Hippocrates. He does so when discussing the meaning and role of stars in the cosmic order, theological questions, metaphysical principles, scientific theories, astronomy and astrology.[21]

3. Pastoral Medicine

Another category of sources where we find Hippocrates cited and quoted in church and theological documents is that of textbooks dedicated to pastoral medicine. Indeed there is a close relationship between the Corpus hippocraticum and theology not only because the Hippocratic writings constitute a tried and tested system of diagnosis and treatment but also because of their human image, their essential Christian basis, and their stress upon the notable similarities between sick and healthy people.

We should also take note of the ethical-medical chapters of the *Didaché* and the way in which they correspond to the writing and ideas of Hippocrates. The Greek physician is referred to on two occasions: when the behaviour of the marriage partners during pregnancy is discussed, and where there is a debate about the therapeutic opportunities offered by folk medicine in cases of epilepsy, something, of course, which today appears highly disputable.[22]

In 1893 E.W.M. di Olfers referred to Hippocrates in his book on pastoral medicine. He was much ahead of his time in his definition of epilepsy as a *"holy disease"* in the same way that every other illness is holy, and observed, in addition, that it was no more holy than any other.[23]

August Stohr makes repeated reference to Hippocrates, in part because he wants to attack a certain form of medicine proposed by the

ancient Greeks, a form of medicine which has much in common with the therapeutic treatment of the soul. In addition Stohr refers to Hippocrates when he discusses the classical idea of *sex res non naturales* and dwells upon diet and upon general customs and habits of an individual's life.[24, 25]

When considering the middle of the twentieth century we can cite Albert Niedermayer who makes frequent references to the *Corpus Hippocraticum* and to its ethical-medical high-point, the famous Hippocratic Oath. Like many other authors (Lichtenthaeler and others) he believes that this oath forms an authentic part of the Hippocratic writings.

In the work of Niedermayer there are arguments in favour of Hippocrates but also controversial statements, especially in the gynaecological field.

Albert Niedermayer has clear ideas about the importance of Hippocrates: "Even though he was a pagan he could today—some two thousand years after Christ's preaching of the Gospel—act as an example and model for doctors who proclaim themselves Christians."[26] Albert Niedermayer anticipated later overall and Wholistic approaches to medicine when he expressed his belief that a true and authentic doctor has a vision of his profession which "has at its base a fusion of biological, anthropological, medical-human, social, and ethical-metaphysical considerations, elements, and factors."[27]

Professor G. ROTH
Professor of Pastoral Medicine at the University of Vienna

Notes

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JESÚS ALVAREZ GÓMEZ

The Care of the Sick in the History of the Church

1. Concern for the Sick Belongs to the Mission of the Church in Terms of Both Her Founding Purpose and Her History

When Jesus entrusted his apostles with the mission of teaching the Holy Law of the Lord to every creature he gave them the power to manifest the same signs with which he had shown that in Him were expressed those promises which God had made to the people of Israel: the banishment of evil spirits and the healing of the sick (*Lk* 16:18).

From the first community of Jerusalem until today, the Church has woven a wonderful garland of love around all of the weak and all of the poor. But sick people, above all else, have been the primary object of her love.

2. Concern for the Sick in the Early Christian Communities

The early Christians did not have before them any institution which gave them an example of how the sick should be treated. In Egypt, Greece, and Rome there was no specific system by which care was offered to the ill.

It is not easy to determine with precision how the Christian communities dealt with sick people because this was a category which was defined in relation to the more general practice of *"helping the poor."* Nonetheless, there are some comments about the subject in the early liturgical and pastoral writings of the first centuries of Christendom. Our attention is drawn primarily to the *Didascalia*,[1] a document which describes the lifestyle of a small Christian community where bureaucracy had not as yet emerged, phenomenon present by the middle of the third century AD in communities with a large number of believers.

In the early communities the person who was ultimately responsible for everybody was the bishop. The most important qualities which the faithful required of a person to be elected to such a position was, according to the *Apostolic Constitutions*, love for the poor he should "love the poor."[2] The *Didascalia* declared: "Remember the poor, extend a hand to them and feed them."[3] In this task the bishop was helped by the deacon, who "had to be the ear of the bishop, his mouth, his heart, and his soul"[4]. As a result, the deacon was ordered to search out the sick, to study each case in practical terms to see if greater care could be given, to bring them the Eucharist, which had been consacrated during the Sunday liturgical assembly, and to help them in a more material sense[5]. The *Didascalia* also encouraged the deaconesses and widows to dedicate especial attention and care to sick and poor women.[6]

This practice outlined in the *Didascalia* is supported and promoted in the fifth century by the *Testament of the Lord*[7], which ordered the deacon to "go into the inns and taverns to see if there was a sick or poor person there, or a sick person who had been abandoned."[8]

At the outset, when the communities were very small in size, the bishop or the deacon looked for a Christian family which was prepared to take in and care for poor people or sick people without relatives to help them. But when the number of sick people grew, as happened in Rome in the middle of the third century, the first hospital-like institutions were created. The acts for the martrydom of St. Lawrence tell us that he created a sanctuary/hospital to care for, and protect, the greatest treasure that the community possessed, the poor and the sick.

Although the principal figures of authority and responsibility were the bishop and the deacon, in actual fact all Christians had to be personally responsible for the poor and the sick. In the *Apostolic Tradition* of Hippolitus of Rome (235 AD), the candidates for baptism were asked: *"Have you honored the widows? Have you visited the sick? Have you performed all kinds of good works?"*[9] And the godfather of every catechumen had to guarantee the good behavior of his godchild before the whole community.

3. Concern for the Sick after the Peace of Constantine

From the year 313 AD onwards, the Church could organize care for the poor and the sick on a very large scale indeed. Institutions bearing a whole variety of names sprang up everywhere and with increasing frequency. Their names reflected the kind of people they cared for: *"hospitals"* for the sick; *"homes"* for the elderly; *"hospices"* for pilgrims; and *"orphanages."*

It was the mother of the Emperor Constantine, St. Helen, who founded the first hospitals bearing the sign of the cross, and it was Constantine himself who built the hospital at Constantinople. The first hospital specifically for pilgrims was that of Sebaste (365 AD), which also took in *sick people*, and especially *lepers.*[10]

During a period of famine in Odessa, St. Ephremus (373 AD) berated the rich for their indifference and with the donations he then received created an "emergency hospital" with three hundred beds. This hospital took in the poor and the sick

drawn from the city and the surounding countryside.[11] Towards the end of the fourth century the community of Antioch became famous for its charitable activity in the health sphere. St. John Chrysostom (407 AD) tells us that there were three thousand widows and maidens in the lists of the poor of that community and that these were cared for daily. In addition, there were *"the sick and the convalescent in the hospitals"*[12].

In the West the first hospital-style instituitions emerged between the fourth and the fifth centuries AD. The Greek term which was used to describe them was undoubtedly influenced by the Eastern model. Towards the year 400 the rich lady of high social rank, Fabiola, created the first Roman hospital *(nosocomium)* in the real sense of the term. This hospital was built on the banks of the Tiber and was divided into different wards containing different kinds of sick people. In addition, the patrician Pammachius established a hostel for pilgrims in the port town of Ostia and St. Paola and her daughter Eustochia constructed eight hospitals in Rome itself.[13]

St. Augustine built a *Xenodochium* at Hippo, and he himself observed that institutions of this kind were already known in Africa before this Greek term became widespread in the Latin world.[14]

4. Monks and Care for the Sick

Desert monasticism in the strict sense of the term, whether expressed by anchorites or by cenobites, did not emerge as a specific attempt to care for the poor and the sick. However, the first hermits, notwithstanding the few resources they had at hand, opened their hearts to the poor and to the sick of the nearby villages, and at times shared their meager goods with the poor and sick of Alexandria. They always did this with the pilgrims who stopped outside their cells.

The colonies of semi-anchorites in Egypt, Syria, and Palestine and particularly the Pacomian monasteries followed close behind in organizing social activity through the creation of hospices for strangers and hospitals for their own monks who had fallen sick.[15]

It was, however, St. Basil who integrated monasticism into the charitable and social work of the Church. He saw it as a powerful instrument of evangelization. This great Bishop of Caesarea in Cappadocia promoted a great social initiative[16] which was subsequently called the *Basiliade*[17] in his honor. It was a veritable town built around his episcopal seat[18] and brought forth the deep praise of St. Gregory Nazianzenus. This great friend of St. Basil praised him for "having imitated Christ's behavior towards the sick, and in particular towards lepers."[19]

In practical terms all of the institutions created from the beginning of the fifth century onwards for the care of the sick of Constantinople, Syria, Palestine, and Egypt were in the hands of monasteries run by monks and nuns. The Emperor Justinian gave a special legal status to these hospitals and he himself set up a certain number. These were well endowed, entrusted to the administration of monks and nuns who were helped by a lay staff employed by contract, and were always under the watchful supervision of the local bishops.[20]

In the West during the Medieval period, when there was no specific network of hospitals, hotels, and inns, the monasteries gave hospitality to travellers—emperors, kings, nobles, and even mere vagabonds. However, primary importance was always given to sick pilgrims and to the sick from the countryside.[21] The Benedictine rule ordered that such people be treated as though they were Christ in person.

In the monasteries medicine was taught and botanical gardens were created which had every kind of medicinal plant available. Lengthy prescription books derived from extensive experience existed side by side with medical texts, and, according to the catalogues of their libraries, both were very large in number. History records the names of many monks who were specialists in the field of medicine (22).

5. Hospital Brotherhoods and Orders During the Medieval Period

Brotherhoods or congregations were created for the hospitals established by kings and corporations. These bodies were independent and were composed of *"brothers"* and *"sisters"* who lived together in communities, and in addition to taking the three vows of chastity, poverty, and obedience, they also took a fourth vow to care for the sick. The most famous of the brotherhoods was the Augustinian brotherhood of *Hotel-Dieu* in Paris, and the statutes of this body were imitated by nearly all the others. In the diocese of Paris alone there were more than fifty hospital brotherhoods. The *Beguine* communities were also concerned with care for the sick, and did so sometimes in the home of the sick person and sometimes in the hospital centers of the Church.

The Medieval period witnessed the first religious orders dedicated to hospitals, such as the *Hospitallers of the Holy Spirit and the Hospitallers of St. Anthony.*[23]

The military orders also established hospitals, in both the Holy Land and Europe, and especially in the Iberian peninsula, where they took care of pilgrims who visited Santiago de Compostela. Certain military orders were famous for their service to the sick, namely the *Hospitallers of St. John of Jerusalem,* the *Templars,* the *Knights of Santiago,* and the *Teutonic Knights.*[24]

The profoundly humanitarian and compassionate spirit of the mendicant orders was expressed in the creation of a large number of initiatives to help the poor and the sick, and in this endeavor their *"tertiary orders"* played a primary role.

6. The Great Hospitaller Orders

The hospital centers for the whole of the Medieval period were holy places and as such were placed under ecclesiastical jursidiction. In order to carry out their tasks these hospitals were usually endowed with a large amount of wealth and in time such wealth attracted the greedy eye of laymen and also of a number of clergy. The most prosperous hospitals fell into the hands of unscrupulous trustees who rapidly despoiled these institutions. Thus it was that many hospital institutions disappeared and on the eve of the Council of Trent care for the sick was almost at an end, notwithstanding the fact that the Oratories of Divine Love had established a large number of hospitals for the incurably ill in Italy.

During the Renaissance a variety of organizations with a social purpose began to concern themselves with hospital care for the poor. Thus a large number of r*oyal, municipal,* and *guild hospitals* came into existence. But this initiative to create

public hospitals was by no means sufficient for the growing number of poor and sick people who had been afflicted by an increasing number of epidemics, and particularly those who had fallen victim to the constant wars of the epoch.

Once again it was the Church which gave rise to a large number of hospital and charitable institutions. The Church did this through the new hospital congregations and orders such as the Brothers of St. John of God, the Ministers to the Sick of St. Camillus De Lellis, the Daughters of Charity of St. Vincent de Paul and St. Louise of Marillac, and through a host of diocesan congregations. These institutions were especially directed towards those social areas of marginalization and illness which were least cared for by the public authorities of the time.

The first real hospital institution to be dedicated to psychiatry was that created in Valencia in Spain in 1409 by the Venerable Father Juan Gilabert Joffr (1363-1417).[25]

A new and vast field for the hospital work of the Church then opened up with the discovery of America. This has been emphasized by Cardinal Fiorenzo Angelini:

"Concern for those who suffer, for the sick and the week, as a fundamental and unifying element in missionary activity...was one of the features of the first evangelization of Latin America, when hospitals and health care facilities were set up, and this was done first and foremost by the religious orders."[26]

7. From "Works of Mercy" to "Social Justice"

The advanced governments of the eighteenth and nineteenth centuries considered the traditional *"works of mercy"* as humiliating for man and confiscated the material wealth with which they had taken care of the poor and the sick. In this way, however, not only did these governments fail to solve the problem of poverty and illness, but they actually increased it because in actual fact the poor became poorer and the sick were less cared for.

However, the Spirit of the Lord Jesus gave life to a splendid flowering of religious congregations dedicated to care for the sick.[27]

The presence of the Church in today's hospital world must not be seen as a mere "*support mechanism"* for civil society. Christians who work in health care practice a profession, but they are also engaged in a *salvific mission*. Their professional expertise is required for their profession, but it is also necessary to their salvific mission.

Rev. JESUS ALVAREZ GOMEZ, C.M.F.
Professor of Church History at The Institute for Religious Life of the Sons of the Immaculate Heart of Mary (Claretians), Madrid, Spain

Notes

1. The *Didascalia* or *Catholic Doctrine of the Twelve Apostle and the Holy Disciples of our Redemmer* comes from the first half of the third century AD. It was written by a bishop to a community in the north of Syria. It was a guide for church discipline and was especially concerned with the sick. The author possessed extensive medical knowledge.
2. *Apostolic Constitutions,* II, 50; cf ST. IGNATIUS OF ANTIOCH, *"Letter to Polycarp,"* 4; JUSTINE, 51 *Apolog.*, 67; HERMAS, *Pastor,* Sim., IX, 27, 2; St. Ireneus, *Adv. Haeres,* IV, 34.
3. *Didascalia,* XIV, 3, 2.
4. *Didascalia,* XI, 44, 4.
5. JUSTINE, i *Apolog.,* 67, 6.
6. *Didascalia,* XV, 8, 3.
7. Strongly influenced by the *Apostolic Tradition* of Hippolitus of Rome.
8. *Testamentum Domini,* II, 34.
9. *Apostolic Tradition,* 20.
10. ST. EPIPHANIUS, *Adv. Haeres,* 3, 55.
11. SOZOMENUS, *Hist. Eccl.,* 3, 16, 12-25.
12. ST. JOHN CHRISOSTOMUS, *In Mat. Hom.*, 66, 3; *Ad Stagyr. Conc.,* 3, 13; *In Act. Hom.*, 45, 4.
13. ST. GERONIMUS, *Epist. 27 Ad Oceanum;* PL 22, 694 and 697; *Epist. 108, ad Eustoquium;* PL 22, 878.
14. ST. AUGUSTINE, *Sermo* 355, 2; *In Job* tr., 97, 4.
15. J. ALVAREZ GOMEZ, *Historia de la Vida Religiosa,* I, (Madrid 1987), pp. 215-218; cf Paladian, *Historia Lausiaca,* 7.
16. Ep 176, 653; Ep 94; Ep 150, 653 c.
17. SOZOMENUS, *Storia Ecclesiastica,* VI, 34; Pg 67, 1397 a: "Basiliade, the very famous hospice for the poor founded by the Blessed Basil from whom it takes the name which it has today."
18. GREGORY NAZIANZENUS, *In Laudem Basilii,* PG 36, 577; Ep 143, 593 a, 488 b-c-. "Go a little out of the town and look at the new town"; cf S. Giet, *Les Ides et l'Action Sociale de Saint Basile,* (Paris, 1941), p. 421, note 2.
20. *Cod. Just.*, 1, 3, 32 and 34.
21. M. ZUNIGA CISNEROS, *La Seguridad Social Y su Historia,* (Caracas, 1963).
22. U. BERLIERE, *L'Ordine Monastique des Origines au XIIe Sicle,* (Abbaye de Maredsous, 1924), pp. 119-120.
23. J. ALVAREZ GOMEZ, *op. cit.*, pp. 187-190.
24. B. RIGALT Y NICOLAS, *Diccionario Historico de las Ordenes de Caballeria,* (Barcelona, 1858); F. CRADINI, *Le Crociate tra il Mito e la Storia,* (Rome, 1971); J. ALVAREZ GOMEZ, *Historia de la Vida Religiosa,* II (Madrid, 1989), pp. 183-186.
25. I. TALAMANCO, *Vida del Apostolico Padre el Beato Fr. Juan Gilabert, de la Real y Militar Orden de la Merced,* (Madrid, 1735); J. ZAPATER Y UGEDA, *Biografia e elogio de Fray Juan Gilabert Joffr, Fundador del Hospital General de Valencia,* (Valencia, 1883).
26. CARDINAL FIORENZO ANGELINI, *La Prima Evangelizzazione in America Latina e l'Attenzione della Chiesa al Mondo dei Malati,* (Vatican City, 1992), p. 22.
27. C. LANGLOIS, *Le Catholicisme au Feminin. Les Congregations Franaises Superieure Generale au XIXe Sicle,* (Paris, 1984); J. ALVAREZ GOMEZ, *La Revolucion Francesa y la Vida Religiosa,* Vol. III, (Madrid, 1990), pp. 503-619; J. CHARRY, *"Le Nuove Fondazioni di Congregazioni dopo la Revoluzione Francese,"* in Vita Consacrata, 5, (1985), pp. 600-612; RAPONIN, *"Vita Religiosa e Carità nei Modelli Storici dell'800 e del 900,"* in Consacrazione e Servizio, 7-8, (1989), pp. 37-46; C. NASTORG, *"Les Religieuses dans le Monde de la Sant en France, au XIXe Sicle,"* in RESPA, 320, (1988), pp. 275-281.

BONIFACIO HONINGS

The *Charter for Health Care Workers:* A Synthesis of Hippocratic Ethics and Christian Morality

I have the honor rather than the task of presenting the *Charter for Health Care Workers* to this international conference. When I thought about the best way of doing this it seemed to me opportune as well as useful to take a broad overall view. With such an approach it would be possible to give a clear presentation of the chief concern which pervades the text, namely that of helping the health care worker to serve human life from its beginning until its natural end. Such service is fully human and specifically Christian. This paper of mine thus seeks, and this is a very important point, to show immediately how the *Charter* is in very practical terms a synthesis of Hippocratic ethics and Christian morality. In order to achieve this rather ambitious goal I will begin by emphasizing the divine origins of each human life and its destination towards God himself. After this I will describe how the figure of the health care worker is a servant to this life and thus, and above all else, to the Author of this life. Finally, I will trace the path of human existence: generation, life, and death, all of which are central reference points for ethical-pastoral reflection and thought.

1. God: The Alpha and Omega of Human Life

When there was no man who tilled the soil or who brought forth water from the earth to irrigate its surface "the Lord God formed man of dust from the ground, and breathed into his nostrils the breath of life; and man became a living being."[1] From this creative act of God the Church derives her teaching that each spiritual soul is created directly by God and is immortal—that is to say, that it does not perish at the moment of its separation from the body at death. Not only this but the Church also teaches that this soul is united once again with the body at the moment of the final resurrection. The life of the human being, of every human being, is not the product of parents or of a laboratory projected and constructed by man. Human life, and the point is not in the least open to discussion, has a divine origin.[2]

A sentence from the Book of Job is very significant here: "If he (the Lord) should take back his *spirit* to himself, and gather to himself *his breath*, all flesh would perish together, and man would return to dust."[3] Of no less significance is Ezekiel's comment on the resurrection: "And I shall put *my spirit* within you, and you shall live."[4] Without the "vitalizing breath" of God man would indeed merely fall back into nothing. But if God gives a soul to the body—that is to say, if he gives life—then it is more than right that He, and only He, attributes to Himself the inalienable and inviolable right to manage and order the life of each human being from the moment of conception until natural death.

John Paul II does not hesitate for a moment to proclaim, with a certain solemnity, the existence of this divine right: "Human life is sacred because from its very beginning it bears the 'creative action of God' and it always remains in a special relationship with the Creator, its only end. Only God is the Lord of life from its beginning until its end: nobody, in any circumstances, can give to himself the right to directly destroy an innocent human being."[5]

Here we encounter the central feature of Christian morality in relation to the sacredness and the inviolability of human life, of every human life, of the human life of every man. This is why Jehovah, when he revealed the ten commandments of the Covenant, put the commandment "Thou shalt not kill" at the center of this Covenant, a fact which deserves special attention. God makes himself not only *judge* of each violation of the commandment in defense of life but also and above all else he makes himself the *defender* of a commandment placed at the very basis of the whole of social coexistence.[6] For good reasons, therefore, Christian morality has always proclaimed and defended and still proclaims and defends today the incomparable value of the life of each human person.

But Hippocratic ethics, expressed in the ever relevant and contemporary famous oath, have also proclaimed and defended this value of each human life and has done so for over two thousand years. It therefore comes as no surprise that within this permanently valid set of ethics there are to be found four key features, as Cardinal Fiorenzo Angelini has pointed out, and these are: "a profound respect for nature in general; a unifying and integral conception of human life, or rather, of the human being; a close and rigid relationship between personal ethics and professional ethics; and a largely active vision of the practice of the art of medicine."[7] For Hippocratic Ethics as for Christian morality, therefore, the life of each human being is a value which cannot be called into question—it must be defended and watched over. In a word, it must be served. If this imperative applies to everybody, it must apply first and foremost and above all else to health care workers. This is what the *Charter* makes clear, a *Charter* which (as I have made clear above) I have the honor to present to this great and august assembly present here today.

2. The Figure of the Health Care Worker

The activities of the health care worker are the expression of a deeply human and Christian act of service precisely because such service is not only of a technical character but also and above all else because it involves devotion to, and love for, one's fellow man, one's neighbor. In their care and concern for the lives of other people, health care workers perform an action which involves the prevention, cure and rehabilitation of human health and the stewardship of life, an action which is truly Christian and human. For this reason the primary and emblematic form of such care is to be found in their concerned and committed presence at the side of the sick.[8]

This is why medical and health care service implies an interpersonal relationship which is very special: it is, indeed, an encounter between trust and conscience. It is a relationship of "trust" on the part of the person in need of treatment and care because he is afflicted by illness and thus by suffering, and of "conscience" on the part of the person who is able to respond to this need through a fusion of care, treatment and healing. For the health care worker the sick person is never or at least should never be a simple clinical case which should be examined "scientifically." He is always a person who is in special need—because he is sick—of sympathy or perhaps of empathy, in the etymological sense of these terms.

"Scientific and professional skill are not enough, personal participation in the practical situations of each individual patient is what is needed." That is to say one needs: "readiness to help, attention, understanding, sharing, benevolence, patience and dialogue."[9] In order to achieve a better and more precise understanding of this *Charter* it is very important to observe that this total dedication on the part of the health care worker to serving each sick person finds its truest "objective" basis and its most pressing "subjective" basis—that is to say its most involving basis—in an overall vision and understanding of the sick man himself.

Understood at their roots, illness and suffering are in reality phenomena of human life which pose questions which transcend medical science and technology. This is because they touch upon the axiological essence of the existential condition of man on earth. From this point of view the health care worker, if he is a Christian and thus a follower of the Good Samaritan or even if he is not a Christian and thus a follower of the most human "secular" figure of Hippocrates, easily understands that his profession is a mission and thus a vocation. His medical-health care activity is thereby a response to a transcendental call which takes concrete form in the suffering and imploring face of the patient entrusted to his care. His loving care for a sick person, characterized by sympathy and empathy, becomes an act of service which is similar to that related by the parable of the *Good Samaritan* and also that required by the oath of the *Hippocratic physician.*

This is why profession, vocation and mission meet each other in the figure of each and every health care worker, and in the light of the *Christian vision of life and health* the health care worker is a minister of that God who in the Holy Scriptures is presented as a "lover of life."[10] To serve the life of the sick man becomes, indeed, service to God and also cooperation with God: the gesture of loving welcome of the weak and sick life in order to give health becomes the giving of praise and glory to God.[11]

It is no surprise, therefore, that the Church "has always seen medicine as an important support of her own redemptive mission in relation to man. Indeed, service to the spirit of man cannot take place fully if it does not place itself at the service of his psycho-physical unity. The Church well knows that physical ills imprison the spirit in the same way as the ills of the spirit enslave the body."[12] The figure of the health care worker is, and thus should always increasingly become, a live image of Christ the Good Samaritan. "Doctors, nurses, other workers in the world of health, and volunteers," John Paul II makes clear, "are called upon to be the alive image of Christ and of his Church in love towards the sick and the suffering: witnesses of the 'gospel of life.'"[13]

3. Ethical-Moral Faithfulness and the Sacredness and Inviolability of Life

The profession, mission, and vocation of the health care worker naturally requires a solid training and a constant ethical-religious formation in moral questions in general and in questions relating to bioethics in particular. In the presence of clinical cases which become ever more complicated and intricate in character because of advances in the realm of biotechnology, all health care workers—but especially medical doctors—cannot and must not be left alone to be burdened by responsibilities which can not be borne. This is becomes even more evident if we reflect upon the fact that many of these advances are still at an experimental stage and are of great social relevance when we come to consider matter relating to the whole world of health and health policy.[14] We can state with certainty that the true and authentic *humanization* of medical science and technology is clearly at stake. In other words, it is evident that in the field of medicine we need to bring about that "civilization of love and of life without which the existence of individuals and society loses its most authentically human meaning."[15] Such, then, is the principal aim of this *Charter*: to guarantee the ethical faithfulness of the health care worker so that he can build—both in his choices and in his behavior—that civilization of love and life invoked by the eminent author of the *Evangelium Vitae.* And it is for this reason that the *Charter* takes as its reference point for ethical and religious reflection and thought that path of human existence which consists of being created, of living and of dying.[16]

3.1. Responsibility Towards the Dignity of Human Procreation

The creation of a new human being is an event which is both profoundly human and highly religious. This is because it involves the unitive love of the marriage partners, a reality which is itself an act of cooperation with God the creator. Because of this it is more than evident that health care workers are called upon to help the parents and marriage partners to "procreate with responsibility, to favor the conditions of such procreation, remove obstacles to it, and safeguard it against an invasive 'technologicalism' which is not worthy of human procreation."[17]

In this service true morality rightly distinguishes between the *therapeutic* manipulation and the *alternative*

manipulation of the human genetic patrimony. "No social or scientific usefulness and no ideological motivation could ever justify intervention on the human genome which is not therapeutic in character, that is to say in itself directed towards the natural development of the human being."[18] The reason for this "absolute no" is to be found in the very dignity of human procreation, and this is because the new human being who is born from conjugal union "carries with him a special image and likeness of God himself: *in the biology of generation is inscribed the genealogy of the person.*"[19] The conception and generation of a new human being is not the outcome of the laws of biology but constitutes, rather, an event of conjugal cooperation in the continuation of divine creation.

Here the *Charter* makes clear that the procreative cooperation practiced by the marriage partners is not only the criterion behind the anthropological and moral difference between natural and artificial methods of procreation but also constitutes the evaluative criterion in matters relating to artificial procreation. "The dignity of the human person requires that he comes into existence as a gift of God and fruit of the conjugal act which belongs to, and is specific to, the unitive and procreative love of the marriage partners, an act which by its very nature cannot be substituted."[20] This is why the appeal to the sense of responsibility of health care workers to promote this Christian and human conception of sexuality is more than right and just. In this way the knowledge required for behavior which is responsible and respectful of the special dignity of human sexuality in general, and the conjugal act in particular, is made accessible to marriage partners and above all to young people.[21]

Health care workers should in the first place help marriage partners to understand the anthropological and moral difference between natural assistance and artificial substitution in matters relating to procreation. In relation to the last question health care workers should stress the wrongfulness of in vitro fertilization with *embryo transfer*, whether it is heterologous or homologous in character. Obviously enough, this moral judgment concerns only the methods of fertilization and not the human being in question who must always be welcomed as a gift of God and brought up with great love[22] Service to life performed by health care workers begins, therefore, with the promotion of this very great respect for the originality of the generation of human beings.

3.2. Responsibility Towards Human Health and Life

The marvelous process of a new human life begins under the wise and loving protection of love at the moment of fertilization. Health care workers and in particular gynecologists and obstetricians should "watch with great care over the wonderful and mysterious process of generation which takes place in the maternal womb in order to follow its correct development and promote its happy outcome through the coming into the light of a new creature." [23]

They must remind themselves first and foremost of the singular dignity of each human life: the dignity of the person created in the image and likeness of God. Health care workers must above all else be aware that each person is a unity of body and soul, and realize that for this reason the person himself in his practical reality becomes achieved through the body. "Each intervention on the human body does not act only upon tissue, organs and their functions, but involves the same person at different levels."[24] From this it follows that the body, by being a reality which is a property of the person because it reveals the person in his relationship with God, with other human beings, and with the world, is the basis and source of moral requirements. The body cannot be treated like an object which belongs to somebody, like a thing or an instrument of which we are owners and arbiters. This is the reason why not everything which is technically possible can be considered morally acceptable."[25]

The intrinsic purpose of the profession of health care workers is the

upholding of the right of man to life and to his dignity. Their duty (which flows from this reality) lies, therefore, in the preventive and therapeutic stewarding and promotion of health and the improvement of the lives of people. "Illness and suffering are not experiences which only affect the physical dimension to man but man in his entirety and in his somatic-spiritual unity."[26] Diagnosis, treatment and rehabilitation, therefore, not only aim at the well-being and the health of the physical body but also seek the integral well-being of the person in a more general sense.

At this point there arises the question of what happens when it is impossible to cure the sick person. In such a case the health care worker is always required to effect and practice all suitable forms of treatment and care but he can also quite rightly interrupt forms of treatment and care which are not suitable or appropriate.[27] Here the question of the humanization of pain through the use of analgesics or anesthetics is very important. Even though for the Christian pain has a great penitential and salvific significance, Christian charity itself also calls upon health care workers to alleviate suffering.[28]

And here in more pressing fashion comes into play the fundamental right of the sick person to pastoral care and to the sacrament of the anointing of the sick. Each and every health care worker is required to create conditions which will enable those who call for religious assistance, whether implicitly or explicitly, to receive such assistance. "Indeed, experience teaches us that man when in need of both preventive and therapeutic help reveals needs which go beyond the confines of the pathology of the body which afflicts him. He expects from the medical doctor not only adequate and suitable care—care which sooner or later will be shown to be insufficient and with obvious fatal consequences—but also the human support of a brother who knows how to ensure that he participates in a vision of life which provides him with a meaning—amongst other things—to the mystery of suffering and death. And where can be found a peace-giving answer to the supreme questions about existence if not in faith?"[29]

3.3. Care and Assistance Until the Natural Conclusion of Life

When conditions of health deteriorate to an irreversible and terminal level, or rather when man enters into the final stage of his earthly existence, health care workers are called upon to give special care and help to the sick person. "Never should life be celebrated and exalted so much as in nearness to death and at death itself... Behavior towards the terminally sick is the acid test of the sense of justice and charity, of the nobility of soul, of the responsibility and the professional ability, of health care workers, beginning with the doctors themselves."[30] This is the moment when dying should be withdrawn from the realm of medicine, concerned as this is in large measure with the biophysical aspect of the illness. At this stage the most important form of care lies in a loving presence which is full of attention and concern, and which instills trust and hope, replacing, thereby, a refusal of death with its acceptance. Powerless as we are when faced with the mystery of death, Christian faith is in such a context the only source of serenity and peace. For this reason, the bearing of witness to faith and hope in Christ by the health care worker is of crucial importance. The creation of a presence of faith and hope is the highest form of humanization and Christianization of dying which doctors and nurses can promote.

In the case of the terminally ill the right to life becomes the right to die in all serenity and with the greatest possible human and Christian dignity. This right rules out every form of therapeutic overkill and, to an even greater extent, every attempt to put an end to life.[31]. *"Euthanasia upsets the relationship between patient and doctor*. With regard to the patient this occurs because the patient enters into a relationship with the doctor which is based upon this latter providing death. With regard to the doctor this occurs because the physi-

cian is no longer the guarantor of life—the sick person fears, instead, that the physician will proffer death. The relationship between the doctor and the patient is a relationship based upon trust in life and it must remain as such. Euthanasia is a 'crime' in which health care workers who are always and only guarantors of life can never participate."[32]

The same is true of abortion even if the health of the mother, a child too many, a serious fetal deformation, and a pregnancy caused by sexual violence, all involve very serious questions. Indeed, life is such a primary and fundamental good that it can be placed on an equal footing (in a situation of equality or even of inferiority) with certain very serious disadvantages.[33] Here the evident synthesis of Hippocratic ethics and Christian morality cannot be contested -both Hippocratic ethics and Christian morality regard all forms of direct abortion or direct (whether active or passive) euthanasia as illegitimate because one is dealing with an act which destroys a prenatal life and with an act of murder which nobody can justify.[34]

Hence the difference from the right to die with human and Christian dignity. "This is a real and legitimate right which health care staff are called upon to safeguard by taking care of the dying person and accepting the natural ending of life. There is a radical difference between `putting to death' and `allowing to die': the first is an act which destroys life; the second accepts life until death."[35]

It is precisely in this acceptance of the end of earthly life that each faithful servant of life watches over this fulfillment of the will of God. He does not for any reason whatsoever consider himself the arbiter of death, in the same way as he does not for any reason consider himself the arbiter of somebody's life.[36] Indeed, it is this context, more than at any other time, consoling for the dying person when the health care worker bears witness to the fact that full participation in divine life is the goal to which man on this earth is called to and oriented towards. In such a context, more than at any other time, is it comforting for the terminally ill to experience the sacramental presence of Christ, "Word of life," *through the anointing of the sick.* "The whole of man receives help through this sacrament to achieve salvation. He feels strengthened by trust in God and gains new strength by which to combat the temptations of evil and the anxieties of death."[37] The same is even more true when we consider the Eucharistic encounter, something which is a viaticum of the body and blood of Christ. In the words of Christ it is a pledge of the resurrection: "who ever eats of my flesh and drinks of my blood will have eternal life, and I will raise him up on the last day."

Conclusion

I hope that I have demonstrated what our president, Cardinal Fiorenzo Angelini, wrote in the preface: that none of the complicated and intricate problems and questions raised by the inseparable existing relationship between medicine and morality can, at the present time, be considered a sort of neutral ground in relation to Hippocratic ethics and Christian morality. For this reason, the *Charter for Health Care Workers* has given rigorous respect to the need to offer an organic and complete synthesis by the Church, beginning with Pius XII, on all matters concerning the upholding, in the field of health policy and care, of the primary and fundamental value of the life of each and every human being from the moment of conception to natural death.[38]

I would like to conclude with a special reference to the progress and spread of the medicine and surgery of transplants, phenomena which guarantee the treatment and the cure of many sick people who until only recently found themselves in a terminally ill condition. Here we encounter a challenge to love of a totally unprecedented character: loving one's neighbor through the donation of organs so that he can go on living. The removal of organs for homoplastic transplants from live or dead donors can take place, but naturally enough within the limits imposed by human nature.[39] In the first case the removal is legitimate as long as the removal does not imply serious and irreversible damage for the donor. In the second case the body of the dead person must be respected as belonging to a human being, even if it no longer has the dignity of an individual and the value bestowed by a person who is still alive. The medical act of transplantation, therefore, makes the act of oblation on the part of the donor possible, a sincere giving of oneself which expresses one's essential human and Christian call to love and communion.[40]

The intention of the *Charter for Health Care Workers* is paradigmatic with regard to service to life, that is to say, in relation to responding to the call of *Christ:* "Vade et fac similiter."

Rev. BONIFACIO HONINGS, OCD
Member of the Pontifical Academy for Life,
Consultor to the Congregation for the Doctrine of the Faith,
Consultor to the Pontifical Council for Pastoral Assistance to Health Care Workers

Notes (*)

1. *Genesis* 2:7; see also 2:5-6.
2. *Catechism of the Catholic Church*, 366; hereafter CCC.
3. *Job* 34:14-15.
4. *Ezekiel*, 37:14.
5. JOHN PAUL II, *Evangelium Vitae*, 53; hereafter EV.
6. *Ibid*.
7. FIORENZO ANGELINI, *Quel Soffio sulla Creta*, (Rome, 1990), pp. 377-378.
8. Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* (Vatican City, 1995), fourth edition, no. 1; hereafter *Charter*.
9. *Charter*, 2.
10. *Wisdom* 11:26.
11. Cf. *Charter*, 4.
12. *Charter*, 5.
13. Quoted in *Charter*, 5.
14. Cf. *Charter*, 8.
15. *EV*, 27, quoted in *Charter*, 9.
16. Cf. *Charter*, 10.
17. *Charter*, 11.
18. JOHN PAUL II, *"All'Unione Giuristi Cattolici Italiani,"* 5 Dec. 1987, in *Insegnamenti*, X/3 (1987), 1295, quoted in *Charter*, 13.
19. *Charter*, 15.
20. *Charter*, 22.
21. Cf. *Charter*, 20-23.
22. Cf. *Charter*, 24.30.
23. *Charter*, 36.
24. *Charter*, 40.
25. Cf. *Charter*, 44.
26. *Charter*, 53.
27. Cf. *Charter*, 64-5.
28. Cf. *Charter*, 68-71.
29. JOHN PAUL II, *"To the World Congress of Catholic Doctors,"* 3 October 1982, in *Insegnamenti*, V/3, 1982, p. 675, quoted in *Charter*, note 212.
30. *Charter*, 115.
31. Cf. *Charter*, 119; 147-8.
32. *Charter*, 150.
33. Cf. *Charter*, 141.
34. Cf. *Charter*, 139; 147.
35. *Charter*, 148.
36. Cf. *Charter*, 114.
37. Cf. *Charter*, 111.
38. Cf. *Charter*, p. 5.
39. Cf. *Charter*, 83.
40. Cf. *Charter*, 86-91.

(*) The quotations from the *Charter for Health Care Workers* have been translated from the Italian edition. The English edition (Vatican City: Pontifical Council for Pastoral Assistance to Health Care Workers, 1995) is now available - ED).

JOHN O'CONNOR

Healing Wounds: The Rachel Groups

Permit me to begin by reading two letters. The first is addressed to the priest-director of our Archidiocesan *Project Rachel* movement; the second is addressed to me.

"I've been wanting to write you since meeting with you last December. I have been referred to *Project Rachel* via a friend...who is very much involved in the anti-abortion movement and serves it so well.

The purpose of this note is to say "Thank you." I'm not sure why it has been so difficult to articulate the profound effect the meeting had on me. Words seem inadequate in this instance to express my gratitude. I have struggled greatly with the aftermath of my abortion. My previous attempts to reconcile were unsuccessful. What was different this time was the absolute and complete acknowledgment of the baby destroyed. It was no longer just a "little bit of tissue" or a "blood clot" that ceased to exist. So much of the pain I've felt through the years has been for that unborn, discarded, and denied human being.

So when you said, "You can name your baby," something shifted for me. I will never forget those words because he then became a baby, at last retrieved from the garbage pail into which he was so brutally tossed. Thank you for acknowledging him, for helping me recover him, for restoring the dignity I denied him. I can now be a little easier with myself knowing he's been taken care of—that he's been lifted from the depths and placed so lovingly in God's care. I've named him Matthew Joseph. I hope you'll say a prayer for him.

I have one more "thank you"—thanks for representing Jesus Christ so well with me".

And the second:

"I've just attended the healing service, *"At Peace with the Unborn,"* held at (our) church. The feeling of peace in my heart right now is beyond belief. The grief and burden that has been with me for too many years is lifted. It was a totally beautiful and purposeful service!

I pray that this service reaches all women who share its need. Thank you for bringing this service to us.

Sincerely,

A Catholic who has come home."

This will be a straightforward, undramatic account of an effort to respond to the multiple tragedies consequent to abortion. The horror of abortion itself provides more than enough "drama."

In the United States today, annually since the infamous *Roe v. Wade* Supreme Court ruling of 1973, approximately 1,500,000 unborn babies are destroyed. The estimate since 1973 is a total of 30,000,000 babies.

The overall destructiveness of the single action of abortion defies calculation, in terms of the lives of countless numbers of mothers, fathers, siblings, abortionists, and assistants. Only the baby dies. The mother and others often live or try to live with souls churning with guilt, minds in turmoil, normal patterns of behavior turned upside down. Some, believing themselves forever beyond redemption, yield to a vicious circle of promiscuity, pregnancy, abortion, time after time, or give up all faith; if Catholic, they avoid Mass attendance and the Sacraments, believing themselves unworthy of the forgiveness promised in the confessional.

Recognizing that many abortions are the result of fear, poverty, or inability to find help, on October 15, 1984, in the Archdiocese of New York, I announced that any woman of any race or religion from anywhere, pregnant and in need, could come to me: that we would ensure free medical care, hospitalization and legal assistance or counseling either to keep her baby or offer it for adoption. I have repeated that offer many times since. Thousands of women have responded; their babies have been saved, their own lives kept relatively intact.

But this effort to prevent abortions is obviously retroactive. For those who have already suffered abortion we offer *Project Rachel*, named after the scriptural "Rachel, weeping for her children; she refuses to be comforted for they are dead" (Mt 2:18). Their need for healing is profound.

Project Rachel is a healing ministry of the Archdiocesan Family Life/Respect Life Office. Trained priests, psychiatrists and psychologists provide individual, spiritual and psychological counseling as well as sacramental reconciliation for women (spouses and friends) who have suffered the trauma of an abortion.

Each case varies; sometimes the priest and the professional counselor work in tandem, sometimes independently.

Referrals are made by parish priests, youth ministers, high school principals and guidance counselors, campus ministers and word of mouth.

The *Project Rachel* office receives an average of 4-6 referrals a week (approximately 250 per year). In each case the woman is referred to a priest and/or professional counselor for individual care.

Since *Project Rachel* is at work in many dioceses throughout the United States, many, many thousands of women and often those responsible for their pregnancies and abortions have found peace—often the kind of spiritual peace they have never known before. Further, recidivism is almost certainly excluded for the future.

Project Rachel is taken to another plane by way of a more recently developed and gratifying effective healing program called *At Peace with the Unborn.*

At Peace with the Unborn is a program designed by the Archdiocesan Family Life/Respect Life Office. It provides regional communal prayer and reconciliation services to those who have suffered the trauma of an abortion. The mothers are frequently accompanied by spouses, parents, and friends who feel they had a "part" in the abortion.

In the context of Scripture, prayer, personal testimony, and Sacramental confession, persons experience a psychological and spiritual healing with God, the Church and with themselves. This program has proved to be an effective witness to the healing power of Christ and serves also as a source of evangelization for those who have left the Church because of their abortion.

Ten regional programs are conducted each year. Approximately 500 women experience this program on a yearly basis. Since the program was initiated in 1989 (the attendance figures have remained consistent) we have reached approximately 3,500 women.

A special dimension of *At Peace with the Unborn* is that this spiritually-oriented program has attracted, as well, significant numbers of women who have not had abortions, but have experienced a natural miscarriage. Many of us are learning that a great number of women bear the spiritual and emotional scars of a miscarriage for many years. It is not uncommon for them to believe that a miscarriage is a punishment of God for a past sin. Their feeling of guilt is often unbearable, not only for the past sin or imagined sin, but because now they believe they are "responsible" for the death of a child, even though they desperately longed for the child to live and to be safely born.

I would be remiss if I concluded without reference to a newly-founded religious community of women, the *Sisters of Life,* as our latest instrumentality for helping women who have suffered abortion to pick up the pieces of their lives. Still in its infancy, the charism of this community is the sacredness of human life itself. They take the traditional vows of poverty, chastity, and obedience plus a fourth vow of dedication to the preservation and enhancement of human life, particularly the lives of unborn babies and their mothers. They are contemplative-apostolic, spending half their

lives in prayer, half in action as an extension of prayer.

The *Sisters of Life* are already caring in a small way for pregnant women, but our goal is to open a major retreat center for both the pregnant tempted to have abortion and women who have already suffered the tragedy of one or multiple abortions. Such women will be permitted to remain in the retreat center in an atmosphere of prayer and of love, until their babies are born, or, in the case of those who have suffered abortions, until their lives are restored sufficiently to face the world again.

The *Sisters of Life* consolidate both *Project Rachel* and *At Peace with the Unborn*, incorporating both into their own lives of prayer and of love.

I cannot emphasize too strongly that, helpful as medical, psychiatric, psychological, and therapeutic counseling and similar support efforts can be (and as one personally trained in Clinical Psychology I value such efforts), the spiritual wounds of abortion run deepest. Spelled out in a brief paper like this, abortion-prevention and post-abortion support programs sound almost mechanical-programmatic organized efforts at social reconstruction.

The trouble with every abortion is that is, profoundly and inescapably works havoc on an individual and unique person, who fits no mold, falls into no organized category. If she has ever had a scintilla of faith, of religious conviction, of moral education, she is crushed with guilt—a guilt that may be driven deep into the unconscious by whatever forces are at work—but which are then a cancer in the very soul.

The mother who has given her children up to death, for whatever motive or however confused and pressured, needs passionately to be convinced more than anything else in the world, that she is forgiven, not by a counselor, not only by herself, byt by God. These mothers must come to believe that God *loves* them, despite, or in a profoundly mysterious sense, even *because* of their weakness.

They have to see themselves standing with Mary at the foot of the Cross, uniting the crucifixion of their own child with the Child of Mary. They have to know that having shared in the crucifixion, they share His forgiveness, that it is about each of them that He is speaking when He cries out to His Father: "Father, forgive *them* for they know not what they do." They must know that it is to each of them that he promises from the Cross: "This day you will be with Me in Paradise."

This is the hope, the shining goal, the fervent prayer of *Project Rachel*.

Cardinal JOHN J. O'CONNOR
Archbishop of New York
Member of the Pontifical Council for Pastoral Assistance to Health Care Workers

JEAN-MARIE MEYER

The Sacredness of Life in Pagan Philosophy

Before defining and describing the ways in which pagan philosophy saw life as sacred, I would like to outline the character and contours of this paper. *De nominibus non curat sapiens* was an important maxim here in Rome many centuries ago. As a philosopher here in Rome today I cannot say that I myself have such a prerogative. Indeed, it is of essential importance to set out the nature of our inquiry.

I. The Sacred: Religion and Philosophy

The religions of the world have always seen life, love and death as part of the relationship between man—or more precisely religious man—and what is above him. These three fundamental aspects of existence have never been seen as merely secular elements. Over the last hundred years religious anthropology has demonstrated (beyond every reasonable doubt) that from the very early years of mankind, life and death have been understood, experienced or celebrated in funeral rites as instruments by which to come into contact with God or the gods. This contact has been seen by social communities as a process which transforms human realities and endows them with something which is divine and sacred. From the point of view of the natural religions, there is nothing difficult or problematic about the idea that life has a sacred character. It amounts to a mere statement of fact. Everything, however, becomes complicated when philosophy enters the stage.

Like me you know about the destiny and history of that strange discipline practiced first of all by the Greeks, a discipline which owes its survival in the modern world to the Romans and to the Arabs.

The unsurpassed Virgil offered a definitive observation on this initiative. He spoke of a *rerum cognoscere causas*. With regard to the Arabs, it should be observed that it is thanks to their translators that most of the works of Greek philosophy have come down to us.

What have these different expressions of philosophy taught us? First and foremost they have demonstrated that except for the example of revelation (I am here referring to pagan philosophy), men are in fact amateurs in the field of wisdom—they are, that is to say, philosophers and not wise men. It was at this point that ancient Greece broke with the rest of the world. China and India, for example, have expressions of wisdom—and very deep wisdom at that—but they do not have a philosophy in the strict sense of the term. However the famous *rerum cognoscere causas* to which Virgil referred well set out the real purpose of philosophy. According to this approach, the philosopher must draw back from myth, accept the limits of his intelligence in relation to the nature of things, and tell himself what experience makes evident: that man comes to understand truth gradually and in a progressive fashion.

This approach places philosophy between what we call science and what we term religion. Like science, philosophy seeks to be objective and methodical in character, but like religion it strives to explore the mystery of man, it wants to extract intelligible gleams from the depths of his character. Philosophy is respectful of the society of men but believes that the gods of the city-state cannot cancel the religious meaning of nature. It is thus no accident that pagan philosophers were often the subject of the hostility of their fellow citizens. Socrates was neither an atheist nor was he irreligious. He merely wanted to show the Athenians that a philosopher could serve the city through the dedication of his life to the cause of truth. Much which was bad was thus said about him: the philosopher did not give suitable reverence to what was divine in the cosmos, and thus he did not respect the gods of the Athenians. This was true because for Socrates the essence of things was not to be found in the stars, it was to be located in the hearts of men, in their free decisions. It was here that the ultimate meaning of existence was to be found and it was here that what was really sacred in life revealed itself, namely the covenant between man and transcendental Justice.

It is here that we come up against the fundamental point of disagreement—or at any rate the difference—between ancient Greek philosophy and the natural religions. Greek philosophy wanted to recognize and to reflect upon the originality of the human person. It thus became necessary to distinguish the human person from

the cosmos, and for this reason the sacred character of life had to be rediscovered by means of a different approach. It is precisely this new approach which we must now subject to analysis.

II. The Sacred and the Essential in Man

I would like to propose the following thesis: pagan philosophy (and in this instance the philosophy of Aristotle) rediscovered the sacredness of man by two routes, both of which respect and throw light upon the relationship between man and what is above and beyond him.

a) Above all, man is taken back to his *origins* and it is here that the sacred is to be found. Indeed, Aristotle was very concerned with understanding the soul of man and with placing man within the cosmos. In a famous page from his "The Generation of Animals" he declares that in the embryo only the intellect comes "from without" and that it alone is "divine" in the strict sense of the term. Its processes, therefore, and what it does, are separate from the body. Although the *soul* is a natural reality and thus a phenomenon which is intrinsic to the living being, the *intellect* does not come from within the individual but from outside him.

The consequences of this belief are immense. It naturally follows from this assertion that the phenomenon which determines the originality and the unity of man has nothing to do with nature. Indeed, at the very heart of the being of man there is something higher and better than the merely biological. The intellect, therefore, places man on the frontiers between the material and the spiritual, and although philosophy must be cautious about the origins of this intellect it is equally true that the philosopher ought to be constantly amazed by the phenomenon of man.

Indeed, man cannot be defined in terms of adaptation to nature because from his very beginnings he is marked by an ability which endows him with a higher destiny. Man at one and the same time is in nature and above nature. His condition, therefore, is by no means easy. However splendid the star-filled sky may be, it is not enough.

And whilst wise men may search for God by observing the heavens, the philosopher rediscovers what is sacred in man by turning instead to the infinite spaces of the human *soul*.

Man, therefore, should not be seen as a small world (a microcosm) which is more ordered than the great world around him (the macrocosm).

Although the human body has sensibility, its sensibility is of a nature known to no other animal. More than any other creature man can feel, can be struck, in a word, can suffer. This, it should also be observed, is the great approach of Greek tragedy. Knowledge is given by experience of life and the vulnerability of our body is the pre-condition to every act of spiritual progress. Aeschylus had this perception in mind when he expressed this tragic wisdom in a simple phrase—we learn through suffering! At another level, Aristotle understands the existence of the hand as a translation, a writing into the flesh, of the power of the intellect. If man has hands, instruments which are universal, it is because he thinks, that is to say he rises above his feelings. As a result the intellect comes from outside nature, governs matter, and enables the body to take part in its own fashion in the power of the spirit. The enigma is thus to be located in the deepest parts of man and radiates out as far as his face and his hands. In overall terms, what makes me that which I am comes from something which is higher than me, and the secret of my existence transcends nature.

b) Aristotle was the heir to a heroic civilization and developed a profound and beautiful conception of the human act in his ethical thought. In his opinion a paradox informs our whole life, and it is this: the mortal being which we are can do something in its actions which is definitive and

which can involve immortality. It is certainly true that the ancient Greeks recognized and practiced the immortality of the hero. Indeed, in the figure of the hero they detected the realized image of the good citizen. All their philosophers, and both Plato and Aristotle, sought what was better and what was higher. What they wanted was to discover "the true virtues *of man* and of the citizen" (The Apologia of Socrates). They also wanted "to become immortal" (*Nichomaean Ethics*, Book X). What does this mean? Perhaps that every man can discover the truth about man by traveling deep within himself. Here also mere adaptation does not guarantee success. For this very reason Pericles was not the mere product of a city-state but a unique and universal model of what the political man should be. By loving and serving his city, Pericles gave a definitive and universal demonstration of the truth of the man committed to, and involved in, his polis. This example of political conduct was fused with a lesson in ethics and metaphysics. This is because what takes place in human life rises above both the polity and what is biological. In the action which truly and authentically involves the human person, there can be found, beyond any temporal measurement, that agreement between now and always which contains a sacred dimension. All things considered, therefore, the holiness of life has two features. On the one hand, it is the *source* of the intellect which asks questions about the world, and on the other it is the *achievement* of man when individual life fully acquires its final and definitive value.

I do not believe that we can find texts in pagan philosophy which express this idea with concepts and notions alone. In order to clarify and investigate this observation I will cite the arguments and words of philosophers who are not usually recognized as such.

III. The Message of Antigone: The Sacredness of Life

Through his *Antigone* the great Sophocles provided us with much more than a message. He offers us a vibrant meditation, a veritable *cry*, on the holy places which unite men after their deaths. Creontes denies the celebration of funeral rites to his brother after the battle against the city. Only Antigone refuses to accept the de-

crees of the Lord of Thebes and insists on celebrating these rites. And because she dared to disobey she was condemned to be walled up *alive*. And here, as you will have fully realized, we touch upon the heart of the subject of this paper. Her gesture has a *sacred element* and Antigone tells us much about life through her strange and unusual death. In order to support this observation I will throw light on certain aspects of this excellent play by Sophocles. First of all, the heroine is a woman and this can but surprise us when we recall that women had a very circumscribed role in the Greek polity. It is certainly true that wives took part in family rites with their husbands but outside the walls of the home, and this was especially true in ancient Greece, the political role of women was of minor importance. This fact brings out the great moral force of Antigone who performs her religious duty whatever the cost may be and does not fail in her duty because of reasons of social convention. However it seems to me that we should focus our inquiry more closely.

At first sight this action of Antigone seems to call the social order of Thebes into question. At the same time a new question is posed: what was Antigone's approach to the sacred or holy if she felt impelled to challenge social convention in this way? Was not the ancient city-state an inextricably bound up religious and political association? Would a compromising of religion not have led automatically to a compromising of the political structure?

Antigone adopts an extremely clear stance. The rites certainly have their social significance and act to strengthen the ties between the living and the dead. At the time of Antigone, therefore, they had an obvious and evident political meaning. But precisely because of this fact they had to be linked to justice or, to employ the excellent phrase of the chorus, man had to "unite the laws of our world with *eternal Justice*." A rite, therefore, had to be assessed and evaluated in relation to justice and without this act rites themselves became a mere arbitrary decree, like those of Creontes. Without justice religion is nothing but a collection of rites without meaning and without a soul. But this religion does not allow Antigone to respect just laws or even to truly and authentically love her own brother. It is for this reason as well that the ill-starred heroine rises above the spirits of her time.

For Creontes the situation is very clear: Heteocles died to defend the city but Polynices died fighting it. The first, therefore, is a hero but the second is an enemy. For Antigone, on the other hand, death puts an end to this antagonism and her lucid sight looks beyond death to the reconciliation of the dead brothers. The city is certainly important but cities are here on earth and do not encroach upon the spirit of the heavenly horizon. Beyond the limits imposed by time and by the city, Antigone understands and recognizes that her brother remains a brother. And she communicates this message at great risk to her own life.

"Antigone with a soul of Light, Antigone with violet eyes," declared D'Annunzio in 1904. I perceive something sacred in the gesture of Antigone. Her self-sacrifice is an answer to the act of sacrilege committed by Creontes. In this descent into the tomb Antigone demonstrates to us unprecedented faith in the value of the good life, a life which constantly challenges death. This challenge involves two directional paths. One is *existential* because the just woman *finds herself face to face with the threat of death.* The other is *metaphysical* in nature because Antigone *knows* that in her act and in her being there is something which can never die, something which death has never been able to destroy. We certainly do not believe that the distance in time which separates us from Antigone prevents her message from reaching our present epoch.

A perennial greatness is to be found in service to the dead and it seems to me that the religious Antigone is a witness and perhaps an educator for the universal conscience.

IV. Conclusion

This woman, because she loved, revealed from the very heart of what was sacred for the ancients in both religious and political terms that there is something irreducible in man in relation to nature (the cosmos) and in relation to the city-state (the polis). She also showed that this "irreducible" presence unites the living and the dead when love is present and operative. But Antigone did even more than this. She showed by means of the eloquence of her tragic gesture that man must place himself in nature and the polis *precisely because of that* which is above him. Perhaps this is indeed an act of "madness" as her frightened sister proclaims but—and this is the hinge point -Antigone knows how to love those people that she loves (*Antigone*, verse 101). There was no better way to demonstrate how the weakness and the fragility of man conceals the incommensurable greatness of love than through the features of Antigone. In giving us the figure of Antigone, Sophocles made this clear. As Hofmannsthal happily points out: "Ich bin der Schwesterlichen Seele nah, ganz nah, die Zeit versank, von der Abgründen des Lebens sind die Schleir weggezogen" ("I am near to my twin soul, nearer, time no longer exists, the veils have been drawn back on the abysses of life").

It is certainly true that Antigone is mortal, she knows this and she says it. She also weights the consequences of her actions. She could have accepted the human love and happiness but like others at other times she is drawn further on by a sense of obedience. It is for this reason that Swinburne makes her speak thus to the elders of Thebes: "People, old men of my city, lordly wise and hoard of head, I a spouseless bride and crownless, but with garlands of the dead, from the fruitful light turn silent to my dark childless bed."

This descent into the tomb contains something which is sacred and holy because we able to see that we are face to face with an exchange with her brother and with the final gift of what she is. She has received her life from her race and from her city. What will she do? What should she do? The timeless wisdom of men enables her to know that life is nothing but a breath and that Hades will have the last word. But this is not the essential thing.

In a fragment of time and space, in this brief life, the pagan philosopher saw that the relationship between mortals and the divine was decided upon. "Amongst so many wonders of the world, the greatest wonder of them all is man" exclaims the heart of Antigone. Sophocles described the *value of life* when he contemplated the fragile Antigone and argued in favor of an act of *piety*. Before entering the silence of death he observed the definitive light of justice shine forth like a lamp.

Professor JEAN-MARIE MEYER
Associate Professor of Philosophy, Paris
Professor at the Faculty of Comparative Philosophy of Paris

LUIGI MARIA VERZÉ

The Religiosity of Medicine

The subject assigned to me, "The Religiosity of Medicine," set within the context of the general theme of this Tenth International Conference, entitled "*Vade et Tu Fac Similiter: From Hippocrates to the Good Samaritan,*" dictates two fixed points which I will deal with in my short paper. However, I feel that it is incumbent upon me immediately to make a statement concerning my honest testimony to culture and personal experience: real medicine, today as in the past, with all its input of technology and science, cannot disregard the fact that man and his life belong to God, whose living impression or image and semblance man bears.

This implies that the action directed towards man's well-being is proportionate to the overall view of the objective: man, a bio-psycho-spiritual entity. Therefore, he is a sacred identity, and mankind as a whole, a sacred intersubjectivity that "crisis," or being ill (this is a Hippocratic term), rather than obscuring, tends to bring out even better.

In other words, I am stating that, today, more then ever before, a pure and simple mechanistically material conception of medicine is revealed as something unreal.

If man is not seen, above all by the doctor, as a living organic part of the universe and God, he is annihilated, and with him medicine is reduced to a new type of empiricism which degrades its charm as an art because the scientific content which is indivisibly biological, psychological-intellectual, and spiritual is divided up into parts.

In fact, while it is one thing to have a generally high consideration of man, it is another, according to Cicero, to perceive a masterpiece of God, the bearer of a *particula divinae animae*.

An organizational-technological view of medicine does not alter its religious aspect; on the contrary, it exalts it if the global and organic value of man is recognized. The whole world is for man and all the laws of the universe confirm and reinforce his supreme value.

It is by virtue of this that Medicine is not only an *ars sacra* but, as such, the crossroads of scientific, philosophical, and theological knowledge—i.e., of general culture.

Medicine is not therefore only an exchange between the doctor and the patient, especially if by health we understand perfect health rather than the absence of disease—i.e., a eucrasic balance among all the components of man: his physical state, his psychological well-being, and his spiritual life.

Eucrasia and dyscrasia still involve Hippocratic epistemology, which refers to the physical components of man as considered at that time.

Today, it has been shown that only the integration of matter, intellect, and the spirit frees the vision of man from—and heals it of—an "objective" interpretation of the individual as a series of organs; immense room for the elevation of the physician is thus revealed which transcends technocratic strategy and by his action acquires a validity suited to the value of the subject, a sublimity that is more solid, more coveted and more gratifying than the expert and immediate result.

History attributes to Hippocrates the merit of having freed medicine from the theurgic conception of the school of Asclepius, from the Theocratic-Hebrew view, and from the vision inspired by the Egyptian current of Osiris (the fisherman of souls), whose school boasted the great champion Himhotep, Grand Vizier to the Pharaoh Soser, architect, doctor, and priest subsequently deified on account of his therapeutic powers by that refined Egyptian civilization, which, with rare splendor, managed to combine art, wealth, medicine, and a relationship with divinity.

Hippocrates, without yielding to either sophism or empiricism, adapted the art of medicine to the Greek philosophical conception of cause and effect .

But, in truth, the school of Kos, founded by Hippocrates at the sanctuary-hospital of Asclepius, had the enormous advantage of focusing its attention on both the person as a value and rationality. This was, in fact, the opposite of the school of Cnidus, which tended to give preference to the study of disease without reference to the individual, a tendency which, after Hippocrates, has penalized medicine right up until today.

I would therefore say that Hippocrates, far from exalting medical science at the expense of the sacredness of the disease and the cure as professed in previous ages, added a fundamental attention to the human value and to the laws of nature created by God which he, as a "periodeuta," or itinerant, studied while roaming from region to region.

The main theme of the *Corpus Hippocraticum* is therefore the centrality of man, the foundation of its so-called deontology, which I would call the imperative of responsibility, an enormous advance with respect to Hammurabi's Code, abounding in tariffs for services rendered and a deterrent for medical errors.

The Oath of Hippocrates begins as follows: *"I swear by Apollo the doctor and Aesculapios and Hygeia and Panacea and by the gods and all the goddesses, calling them to witness..., that I will adapt my way*

of life for the good of my patients.... In whatever house I enter, there will I go for the benefit of the sick. Whatever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be spread abroad, I will keep silence thereon, regarding such things as sacred secrets." All this contains that wealth of culture and medical knowledge of which Hippocrates, a contemporary of Socrates, Plato, and, above all, Pericles, was and still is an aristocratic example.

There is enough information to justify the comparison between the Good Samaritan and Hippocrates.

The Samaritan is definitely not conditioned by class or by religious beliefs. He does not resort to mysterious mediations. He only does what reason and his human share in responsibility impose upon him, from subject to subject, which is like saying from neighbor to neighbor. For him, too, it is the human value that transcends racial discrimination and projects him with all his belongings, bag included, towards the salvation of that value: man.

Hippocrates' pact is medicine/art to be regulated according to the dimension of man, an art to be both learnt and transmitted, governed according to its operative contents, which render it sacred—much more than simple anthropological reasoning.

The human value is saved only by relating it to God.

He who dictated the law applied by the Samaritan gave it its amplitude by taking on a human measure. God made himself human and pronounced the formidable basic rule of all ethics and all professional deontology: *"Love one other as I, the God-Man, have loved you."* It is a dimension infinitely wider than the Levitic precept, *"Love thy neighbor as thyself."*

All our medical science that studies the combinations among cells, molecules, proteins, and genes fits within this dimension.

Our increasingly advanced technology also falls within it. The modern concern for the true humanization of medicine also falls within it, with something left over for an all-encompassing medicine projecting man towards a perfectly eucrasic body, intellect, and soul, as God planned him and wanted him from the beginning.

Hippocrates, devoid of theological-Christian notions, was only able to anchor the ultimate direction of his medicine upon the testimony of the gods.

Jesus Christ, who ordered his disciples to heal—to heal unconditionally as he did—restores human value in the mystery of God, in the face of which there is nothing but reflection, coherent operative adherence, and love: *"Go forth and heal—you have received freely and freely you shall give."*

Reducing medicine to pure professionalism, however hyperspecialized and technologically supersophisticated it may be—or even thoroughly humanized—without this transcendental breath—which not even Hippocrates, as the founder of biomedicine was able or wanted to free himself from—will always yield an impoverished, mechanized medicine, at best more philanthropic, or, at worst, prostituted for objectives that are unworthy of a holy art.

At the cost of being labeled a reactionary, I must honestly express my conviction that if medicine is not religious, it is not curative, nor is it useful in its role as a promoter—or, rather, recreator—of the whole man.

A religious medicine, on the other hand, cannot lack professionalism or modernity, nor can it fail to integrate itself into the human sciences, such as philosophy, anthropology, logic, ontology, psychology, and theology.

It cannot limit itself to being a curative medicine: it must, above all, be preventive—i.e., it should promote the veneration of the body, in which intelligence and the soul are included.

In short, in order for medicine to be complete and consequently religious, the best in intellectuality should be invested in it. This means: the study of the organization of matter, of the language between one cell and another, between molecules, between proteins, between genes and in all this communicating, one might say, at minimal levels, and the relationship with the organic degrees of various systems, including the neuronal and cogitative ones.

Bio-imaging, chemistry, physics, telemedicine, and the engineering of macro- and micro-structures are involved at the highest levels. I am thinking of the mechanism, which has today been facilitated, of optic fibers, computerized systems, and information science, which should render the relationship between two people, the patient and the doctor, the patient and the healthcare worker, as close and as immediate as possible, not only for psychological reasons but also from a point of view, of intervention and collaboration.

Religious medicine is also occupational medicine because it is social medicine. It is easier and more intelligent to construct a machine that is strong and well-equipped rather than to repair damage and deficiencies. On the contrary, damage and deprivation are the downfall of medicine and consequently of science and the entire society.

In the same way as the underestimation of an adequate tropical medicine that forces us to reassess our consolidated microbiological and pathogenic paradigms would, as with AIDS, become a multiple defeat.

For a complete and realistically religious medicine, as a thriving civilization headed, without any possibility of return, towards the shared identity of a global multi-ethnic village, the mentality that no one can feel sufficiently healthy as long as there is a sick man in the world urges us on, in the same way as no one can feel sufficiently cultured or well provided for as long as illiter-

acy and starvation still exist.

Real and consequently religious medicine cannot fail to be bio-ethical—indeed, the expression of the most mature form of ethics.

From the little that I have mentioned until now it is fairly clear that the sacredness of man and his life lies within his own being and that from there, and only from there, are plausible medical ethics created, in the same way as it is from there that we will reach our guarantor, who is God himself.

Hippocrates, the scientist, doctor, and humanist, had already denounced the insufficiency of the ethics of responsibility (a subject later put forward by Max Weber) or of the categorical imperative, which among other things, at the very end, Kant also recognized as being too weak; so much so that he decided to associate it with the idea of God. In the Hippocratic approach, it is clear that responsibility stems from within oneself; it resounds in nature; it is rooted in the fellow-citizen of the world. And when, above all, you, the doctor, find yourself dealing with naked, lonely men, it forces you to be a man, and, as such, to assume the kind of responsibility that transcends space and time, encouraging you to form an alliance with the Eternal.

The ethics of responsibility, to be such, cannot be born or die within the doctor himself, here and now. The history of the universe is the spectator of an epic factor which is the life of man in which all his *intelligence*, by virtue of his nature, is involved and, with him, God himself.

In my modest everyday life I continue to observe how the power of the doctor-scientist is gradually beginning to espouse the awareness of responsibility, almost like a code of ontology, *intra et extra personam*.

The awareness, that is, that what one is and one's relationship with others is the essence of one's own existence. The divide between scientific research and the value judgments fought for, almost in desperation, by Max Weber in his denial of the enlightenment, historicism, Darwinism, and materialism, is unconvincing, just as a man who is cut in half is also unconvincing. The passion for biotechnology and genetic engineering is a demonstration of this.

And at this point I must rush ahead towards a strong conviction that I will deal with further on.

The Christian hospital is the direct heir of a centuries-old cultural and religious tradition rooted in the depths of man as such—i.e., as created by his Maker.

Therefore, the Christian hospital is a temple where medicine is a sacred ministry, where research at the service of life is compulsory, where science and faith are twins with the same dignity, where all sciences—biology, clinical medicine, philosophy, anthropology, and theology—

form a coalition, without sinister guardians, in defense of the whole man. Life with everything that composes it, including suffering, is not an inaccessible mystery, but rather a personal mine that can be learnt about through intelligent exploration.

The religiosity of Medicine?

When one says that man is the image of the Infinite (and every doctrine, all philosophy, and all civilization do everything possible to demonstrate this and interpret it), one is dealing with a subject of gigantic proportions: from the organization of living material—cells, molecules, proteins—to relationships with the cosmic and metaphysical environment to inalienable supernatural needs.

Man is an indivisible whole of complex parts. When one takes up one of the parts without taking the physical and metaphysical whole into consideration, one fragments the mosaic, thereby running the serious risk of failing to understand the idea which is the beauty of the masterpiece—man taken from the existing universe like a magnificent sculpture that inspiration sculpts from the marble mass endowing it with a profound and deep personality.

When creating man, the Omnipotent endows him with his indestructible soul, thus producing a complex and complete work.

Allow me to deduce that the amazement—*vidit quod erat bonum*—on the part of both the astonished creation, whether intelligent or non-intelligent, and its artist, is perpetually concentrated in human reality, understanding to be reality everything that man is, not what we normally assume because we do not yet know ourselves well enough. Hence the reason and the aim of this research from Hippocrates until today and right up to the end—i.e., until the conquest of the whole truth about man and his habitat.

To miss the target is impossible; one can delay it, by virtue of the admirable endowment which is freedom, but not miss it. This would be the same as admitting the failure of systems, methods, and the achievements attained in all fields. Man, the real man, cannot fail without causing the failure of God himself, who for man has played his own card: Christ.

Therefore, the success of man is directly and gradually proportionate to the knowledge of the physical, psychophysical, and spiritual man and the architectural gestures of God, who created him.

Blood, phlegm, yellow bile, and black bile: Hippocrates had only these vital humor at his disposal, not electrons, molecules, cells, capillaries, chromosomes, genes, physiological systems, etc. Yet he did possess the concepts of awareness, equality, and a social, moral, and aesthetic sense, fundamental products of the religious sensibility that induced him to cure and to educate with religious seriousness.

If we can accept, as affirmed by the atheist Ludwig Feuerbach, that religion is the basic distinction between man and beast, we must also affirm that only religion can give one an intuition of the authentic and

integral dimension of man, of his potential, of his limitations and the resources to overcome them. Therefore, far from rejecting science, as urged by Claude Bernard in a moment of anarchistic need, far from perceiving in science the enemy or step-sister of religion, we see that science and religion are integrated by the knowledge and the relaunching of man and the formidable patrimony that exists within his head and his soul.

The universe expects the life of thought from man.

Indubitably, health care has made enormous advances. Many infectious diseases have been overcome; others are under bombardment by scientific research. But the increase in mental diseases (and drugs are a sign and a product) does not meet with a proportionate counter-attack.

It would appear that here, above all, room should be given to the *"implementation of preventive and recreational medicine, the only medicine worthy of modern man, because this is the scientific medicine of the future, towards which evolving man is oriented as a personal subject with this preordained vocation"* (*Faith as a Work*, p. 160).

I mean mental healthiness, balance, and development.

Can it be affirmed that the average improvement in good looks and physical well-being corresponds to an improvement in the average level of health-care and consequently mental and moral development?

Authentic religious medicine cannot fail to notice that the best part of the admirable human complex is the mind, on which the rest depends; appreciation of man's own nature depends upon it, along with reflex knowledge of ourselves and the grasping of our connatural transcendent dimension. The real dimension of man lies in the knowledge of himself and his own mind.

Man's instant, which is valid forever, is drowning in a collective psychology of overcrowding and noise. The space for thought is becoming frighteningly restricted.

Man, the measure for everything, runs the risk of not having the strength to withstand the scientific product of his own mind if he does not make the mind able to reflect, in fact, about everything.

Hence the priority of curative and preventive medicine for that principal component of man which is the equilibrium and development of the mind, the starting point to enter, after the industrial, tertiary, and telematic age, into the age of wisdom, as I dream of it, the adult age—i.e., of a humanity where science, thought, and love will expand towards truth according to a design and an itinerary illuminated by wisdom and knowledge.

Everything that I have said until now is only a very modest and indispensable preliminary to what I now want to say about the religious concept of medicine contained in *et tu*

fac similiter—i.e., simply do what the Samaritan did who is Christ, doctor and priest, and who is anyone who has decided to continue his work.

My problem lies in the shortage of time assigned to me.

I will venture forth with the synthesis in this sea where I feel I can swim more easily because it is more familiar to me.

I mentioned that the Egyptians considered the sense of life too exceptional not to give it tombs—the prelude of eternity—and not to recognize the art that preserves life, when this art is intelligent and effective, like that of Himhotep, comparable only to divine nature.

I also mentioned that Asclepius considered medicine a sacred and holy act.

Hippocrates made an anthropological science of it. His medical doctrine advanced the theme of a social pact by virtue of which the doctor is recognized as having a power controlled by a triple authority: conscience, *kolis*, and gods. In this way all the old and new masters had an inkling of the sacredness of man, his existence, and his life.

The religiosity of Medicine?

I will here forego, to my regret, mention of the religiosity of Mohammedan medicine, or what is referred to as alternative medicine, normally rejected by advanced society, but which it would be particularly useful to acquire and include. I am referring to natural medicine and the Oriental Chinese type, each of which is far from devoid of wisdom.

I will save room for a brief reflection on the Medicine of God—*Raphael-Ref-El*—as presented in person by Jesus, the Christ, son of David.

With Christianity—or, rather, with the irruption of God into flesh and blood in the history of man—the religiosity of medicine is the medicine practiced by God himself, which we therefore can and must borrow: *"Go forth, teach, and heal."* A command/charism to "heal" which makes the doctor an authentic priest, a scholar who then becomes a teacher—*"Teach"—and which binds him to an anthropological—indeed, theoanthropological—universalism:* "Go forth." "Everything that you do unto even the least will be considered as having been done unto me," God, the son of man.

A charismatic command capable of producing hospitals/temples, as foreseen by the Greek genius fascinated by man in Kos, Epidaurus—Alexandria: temples-citadels of living medicine, of art and science, of philosophy and the worship of divinity, the proud friend of man.

It is hard to say whether Christ spent more of his time teaching or healing. He did not need to study. He healed everyone, even when the sick ran after him beyond the lake, in the shelters where he rested.

Matthew says that Jesus welcomed sick people even late at night, to the point where his closest helpers complained because they did not even have time to eat (Mt 9:35; Mk 3:10; Lk 6:18-19). Jesus

the doctor teaches, heals, and prays at the same time.

It must be recognized that the ministry of Christ was developed between two types of manifestations that are inseparable from each other, like two arms of the same body: a) caring for minds and souls through the communication of the new, revolutionary message; b) caring for people's skin, a care included in that message. This is exactly the same legacy handed down to his disciples: *"Go forth, teach and heal."* Not: *"Go forth, teach, heal,"* but *"Go forth, teach and heal."* Almost as if teaching without healing loses effect and healing without teaching means only halfway healing.

When Jesus comes up against serious disease or death, he prefers strong prayer and then works unerringly even when it is a question of a putrefying corpse (Mk 7:34; Jn 11:41-42).

Nothing could be more spiritually sublime, more bodily human. From the Father, the origin of life, to matter and to the complex mystery of man, with the intermixture of power and fragility, of ethereal aspirations and apparently profane ties.

In Jesus, son of David, everything relative to man—hunger, ignorance, sin, disease and death included—are brought back into direct relation to God the Father.

Indeed, the acute phases of human life, such as disease and death, are an acceleration of the agreement or alliance between God and man. Nothing could be more realistic and at the same time more existentially religious.

Disease and death attack man's roots, but from that very place, almost by osmotic pressure, they distill the religiosity or sacredness of medicine and suffering.

If medicine eludes this evidence, it commits an omission: like causing a plant to lose its color or become dry by keeping it in the dark.

"Be healed and sin no more." This is Jesus' pharmacological formula which, starting from the roots of the individual, invites him to look within himself; it heals the body and recomposes it eucrasically in the relationship with its creator.

Jesus the doctor heals man in his entirety, not only his organs. This would appear to be obvious, above all, for those who are familiar with Christian doctrine. But reality is very profound and involves the entire human being, his intelligence, his desire, his failings, and his suffering.

The message and coherent practice of Christ, starting from the bosom of his father, with his entrance into the world of flesh, through the cross and until the resurrection of the same flesh, do not leave any room for doubt or errors.

Suffering? How is this reconciled with the precept of healing? The answer always lies in Christ: in the same way as the beatitudes of poverty, affliction, and persecution

are reconciled with the parable of Epulone, with the admonishment about compassion *("Be compassionate and you will find compassion")* and about condemnation *("Do not condemn and you will not be condemned").*

Suffering is an exquisitely human heritage, but this should not frighten us in the scientific battle against disease, against death, and against ignorance.

Consequently, the modern hospital cannot but be a Temple of Medicine—science and suffering.

To relegate suffering and illness to the obscurity of futile dissolution is not proper to an intelligent being. To render them sacred is not enough, if we remove from illness and death the attribute of interiority and thus the chance to experience them in wisdom while combating them with all the potential of science and social organization, in order to overcome them.

To undergo suffering and death religiously is not the same as to undergo them with passive resignation.

Hippocrates taught something similar when he said that fever should be seen as something positive, as a sign of an ability to combat which heralds victory: *crisis* for *eucrasia*.

Compassion and comfortable pity are the echo of resignation, synonyms of surrender and disengagement, in contrast to the book of Wisdom, which says: *"God did not create death; he created everything for existence; the creatures of the world are healthy; in them there is no poison of death";* and I say that the poison that exists should be eradicated according to the following logic: God gave the virgin world to man in order for him to perfect it gradually.

Quite the opposite of a contrast between religion and science, between body and soul, between secularism and the confession of faith, between science and values!

Like man, medicine is sacred—indeed, it is a priestly service inseparable from others. The true doctor is a truly religious person—in fact, he is a true priest of God on high.

The Gospel of Jesus Christ leaves no doubt: man is a single biopsychospiritual *unicum*.

Here lies the choice: either we accept the Gospel at its word, and we must be sure that our deeds fit our faith, or we accept it in part—i.e., as an excellent abstract doctrine—and consequently we must also accept the definition of the atheist Jew Sigmund Freud: too many Christians are only baptized half way.

The Holy Father, Pope John Paul II said that the credibility of the Gospel is decided in terms of holiness. The notion of man poses the care of his life as an exercise for all knowing and doing, an exercise for which religiosity is the reason and the objective.

An exaggerated evaluation of man? Without Christ it would be. Indeed, without Christ, man would be his own enemy, as many who did not know Christ, starting from Plato, considered man in terms of insurmountable dualism.

And what medical person working for the good of life can ignore

Christ?

Inevitably, he will work as a *medicus naturaliter Christianus*. In fact, God by his incarnation in Christ, takes the entire universe with him in polyphonic harmony.

This is the *mysterium Dei*, or the secret of the king as revealed by the archangel Raphael to Tobias' family. In my experience, I have verified that the true doctor, even the doctor who considers himself an agnostic, feels a mysterious vocation stirring within himself.

I hear my public asking a question: Is an achievement of this religious-cultural and structural scope possible today?

I think that it is, on condition that one is able to overcome the mentality of opposition between science and faith, between secularism and religious conviction.

Professional Medicine? Yes.

Sophisticated Medicine? Yes.

Anthropological Medicine? Yes.

I propose and, as an advocate of a new medicine, I promote a sacred medicine based on the concept that, thanks to the incarnation of the Word, the seed of God is infused into man's entitative substance.

Medicine, the crossroads of global culture, uncovers this and derives energy by magnetizing the laws of the universe for perfect health care.

God has decided to graft himself onto humanity in a vital encounter. Life has become a new divine power because God, after creating it, experienced it in his own person. Healing thus lies within the logic of the irresistible redemption that the divine seed provides without respite.

The new appreciation of the life of the body is the effect of Christ, who restored it to its correct sense, that of the children of God, all equally opposed to hate, injustice, and discrimination based on race, nationality, or class.

Every form of renouncing the healing and veneration of life means forsaking both science and God. Nobody has believed in man so much as God, who is incarnated in man, bestowing upon him all the necessary resources for both bodily and spiritual growth which will lead him to measure himself against God himself, to become body and soul with the divinity.

Every effort that preserves life and renews it is addressed both towards God and towards civilization.

Christ orders us to heal and gives us the power to do so. All this is by virtue of an important precept: love of they neighbor, of which the Gospel is a unique tapestry which cannot become frayed.

The Samaritan becomes a healthcare worker by virtue of love; he organizes himself and works on his own. He pays, although this is not required by law. The index of commitment is love alone. The only way to practice medicine and to teach it. Love enables us to recover awareness of the unitariness of man and the real active core that balances the universe of his cells and his metaphysical structure.

This living core is individual intelligence; it is the immortal soul in whose depth truth lies: God has created everything for love and pervaded it with love.

Love is the principle with which life itself is associated; it is the substance, the cause, the goal and even the most efficient and overwhelming means of caring for it and making it vital.

Love is an essential voice that moves without stopping from the unknown depths of *Immotus:* an eternal ontology made of love.

Man and myriad beings welcome it. They themselves, the product of love, shine with love and are animated by it; they transmit it through their works, those for life in particular, like a hymn of pure prayer.

Rev. LUIGI MARIA VERZÉ
President of the Centro San Romanello del Monte Tabor Foundation, Scientific Institute, St. Raphael's Hospital, Milan

SERGIO COTTA

Primum Philosophari?

The title I have given to this paper is neither a challenge to common sense nor an official defense of a category of knowledge philosophy or of a caste of philosophers, a challenge, that is to say, promoted in order to lower the prestige of medical science and its promoters and practitioners. To do such a thing here at this conference would be absurd, first and foremost because it is a challenge which could be so easily defeated.

This title should be understood in the light of a paradox, and a paradox in its most authentic message does not aim, as is often believed, at the creation of wonder at its purposeless extravagance. It aims, rather, at revealing an aspect of truth which has hitherto remained in the background. An initial recognition of truth is a part of the essence of paradox, and the same may be said for the reasons for that which is not paradoxical but which is a shared and trusted way of perceiving and thinking.

In our case we have before us an ancient maxim which has been repeated for centuries it is no accident that it is spoken in Latin! This maxim upholds the primary importance of living the philosophical life. We should not however halt and stop at the interpretation given to it by the individual who is forced to accept events or by the libertine who seeks only to live as he pleases whatever the outcome of his actions may actually be. If we look closely, the maxim we have before us does not immediately set one value against another it does not involve, that is, a choice between living, on the one hand, and philosophizing, on the other. On the contrary, it establishes a scale of values between these two separate options—a *first* and a *then*—which certainly does not exclude the value of philosophical knowledge. Nor could it actually do this, and this is because there is a shared belief that the world of values is the theater of operations of philosophy whereas the world of facts is the realm and kingdom of science. That "then" thus indicates the subordination of philosophizing both as regards *relevance* and real effectiveness in relation to the science of living (if we can term it thus) and also in matters relating to cognitive and operative abilities and capacities.

Living therefore takes pride of place over philosophizing at the level of facts and the reasons for this are as follows. In the *first* place there is an elementary reason: not all of the living are philosophers but all philosophers are living. And philosophers have a primary need to live in order to be philosophers. It is no accident that the suicide rate amongst this category of people is very low, and this despite the fact that in their writings they praise suicide. In the *second* place most of modern philosophy argues in favor of the relativism of values. Living, however, requires the certainty of facts and not the certainty of opinions. In the *third* place,

Indeed, in searching for certainty the sick person can become inextricably involved in what the great anthropologist Claude Lévi Strauss called "the thought of the wild state"—that is to say, thought which is emotional and not reflective and which is very immediate because of the urgency of the real situation which is present. In such a state of affairs the sick person could also turn to a charlatan or to a practiced healer. But this does not demonstrate that in such a situation he needs or feels the need to turn to the person who really *knows* (or thinks he knows)—that is to say, to the man of *knowledge*. In conditions which are culturally and psychologically normal, the man of knowledge is a clinic known for its diagnostic and active capacities and abilities or rather, in emblematic fashion, he is a medical doctor. The sick person turns to him before all others (or to him only) in order to ensure that his health is promoted and defended he does not turn to the philosopher.

The philosopher in the strict sense of the term, in my judgment, is unable in practical or rational terms to dispute the validity of the above outlined arguments. He is, however, able to support and promote lines of thought which are not incompatible with such arguments—lines of thought which are by no means of no consequence. In truth the ordinary man, and not only the philosopher, is not content with any kind of life, and not even with that healthy life which the medical doctor can provide him with through his science and knowledge. He also wants a serene life, a life which is, so much as this is possible, happy; naturally enough, good health is an important component part of such happiness. But it is not the sole element which has to be present. Other factors which are not connected with the world of medicine also come into play and these enter into the sphere of competence of the philosopher (in the broad sense of the term, referring also to the theologian, the master of spirituality).

In this way of looking at things the value of life is not called into question. What is important is life as a *value* or rather, in order to escape the imprecision of words, the *absoluteness* of the value of life. A number of real reasons which are by no means of little import call this absoluteness into question. They take many forms and can be incremental

in their character and effect. I will limit myself here to dwelling upon three principal categories.

On the one hand there are the many reasons for unhappiness which spring from serious and damaging conditions of health (chronic or incurable illnesses or illnesses which are in their terminal stage, handicaps and so forth) or from economic, sentimental or moral conditions. I am not referring here to cases which lead to suicide, a minority phenomenon which is nonetheless, and in worrying fashion, on the increase. I am thinking instead of situations which are far more widespread, situations where life seems to be a very heavy burden to bear, a kind of trial and tribulation.

On the other hand, there are the diametrically opposed reasons: those touching upon strength of the spirit and which involve taking upon oneself, for oneself or for others, a great and onerous burden—a weighty burden which can even go so far as to confer upon the voluntary sacrifice of one's own life the very dignity of a solemn and commanding *duty*. This duty, when neglected, can well lead to the loss of one's own personal identity. An ancient Roman maxim of Stoic origins has given lapidary expression to the basic features of these positions: *"Propter vitam, vivendi perdere causam"*—in the name of life one loses the reason for living.

Finally, the value of life comes to lose its absoluteness not in a painful fashion as is the case with the first example, nor in burdensome fashion as is the case with the second, but through a process of sublimating hope. I refer here to the convinced religious belief in personal immortality which is shared by the great religions and in particular by those which can be traced back to Abraham. Christianity expresses this belief in another succinct formula which is much more enlightening than the Stoic aphorism, a formula which runs: "vita mutatur, non tollitur." Life—that is, *our* life—changes form, but is not taken away. Indeed, we are given *real* life, as St. Paul declares with radical incisiveness: "for me living is Christ and dying is a triumph."

This is certainly a religious belief but at this point the tradition of great philosophers adds great persuasive force. This is a tradition which goes from Plato and his *Phaedus* to Kant and his *Critique of Pure Reason*, and which includes great poets and their works such as Dante and his *Divine Comedy* or Goethe and the final triumph of *Faust*, a work translated into music and spread through the universal musical sounds of works by Gounod and Boito.

From all these points of view, however different they may be, the contribution of philosophy is decisive in relation to the criticism leveled at the *absolute* value of life. Even though relativized, the value of life nonetheless remains of the utmost importance because it constitutes the necessary condition behind whether the individual decides to respect life (and to what extent he should do so) or whether he abandons it. In taking these decisions he makes a judgment of value (which is thus philosophical) and not of fact (which is thus scientific). Furthermore, when one is dealing with the defense and promotion of health it seems reasonable to propose that the knowledge (science) of the person who is qualified in matters relating to health—the medical doctor—must not only precede but must also prevail over the knowledge of the philosopher or of the person who takes his place. It should be noted above all else that in this way a modern epistemological distinction is fully respected, a distinction which attributes to science the study of facts involving that which is, and attributes to philosophy the study of values, the evaluative assessment of that which *must be* done, which is a moral task.

The so-called "Hume's law" is invoked here. This law argues that it is fallacious to infer what must be done from what is. But it is precisely to the field of life and health that this "law" is not applied in real terms (and indeed it could not actually be applied in rigid terms). On the other hand, this is not implied in the thought of Hume, a philosopher who was careful to adapt feeling to utility (even to the point of justifying disinterested and selfless sacrifice). Indeed, it is precisely the practical relationship between medical doctor and patient which brings out the reality of the curative synergy which exists between the scientific diagnosis and the human understanding of the sick person.

But although it may well be easy to justify and propose this synergy in theory, it is by no means an easy task to achieve it in practice. The most common method chosen today is that of the creation of committees made up of experts drawn from various fields: doctors, psychologists and moralists, whether believers or non-believers. It is difficult to assess and evaluate the results of such activity, results which are often the noted fruit of compromise. It is also more than probable that more cannot be achieved given the present state of Western culture which has become strongly influenced and conditioned by relativism. This procedure of creating expert committees, however, remains notably inadequate. It would be rather difficult for a comparison and an encounter between a plurality of forms of expertise in such varied and variegated fields of knowledge to give rise to rigorous and verifiable forms of truth.

Given all these above-outlined considerations, it is possible to say that the contribution of philosophical knowledge is certainly of evident relevance. This is because such knowledge is able to enforce and uphold the case for, and the arguments of, morality in the field of health and health care, both in relation to prevention and as regards cure. The role of philosophy is not merely of a residual character but at the same

time it is not confined to the realm of morality, as is usually believed. The fact is that medical science and philosophy share a common purpose in their pursuit of knowledge, and this marks them out from such scientific disciplines as physics or chemistry.

This subject is *living* man, in himself, in his indivisible psychosomatic entirety (in the broad sense of the term), man the living synthesis of physiological-impulse and spiritual-reflexive nature. It is this anthropological constitutive synthesis which gives existence within us to that phenomenon of morality which in turn is an ability to judge our own actions and our own deeds. From this point of view curative synergy is not only a practical necessity by which to effect technically sound treatment and care. It is also an answer to the profound moral need to defend and promote the individual human being for what he really is. In this way the contribution of the philosophy to the field we have under consideration here lies in uniting the (morally) *good* life with the (scientifically) *healthy* life.

But the task of philosophy is not confined to determining moral responsibility in the field of health and health care. It is able to supply a justification for itself which goes even deeper. Here today it is not only a duty to refer to the testimony of Hippocrates—for the philosopher such a reference is a necessity. It is certainly true that the anti-abortionist oath which bears his name is to be placed within the realm of morality. This is so for two reasons. The first reason is of a formal nature: an oath establishes what must be, and this "must be" (the *sollen* or the *ought*) is the form that morality takes. The second is of a substantial character: *this* oath obliges and commits those who swear it to respect human life at the moment of the emergence and appearance of life.

All this is very obvious, but only at a primary level of observation. A more careful examination might lead us to be amazed at the categorical tone of the conclusion. Classical Greek culture had a high sense of life which was seen as a radiant condition which operated in opposition to the desolate and inert darkness of the World of Shadows—Hades. However, life is seen as being subject to destiny, to the sacredness of a fate against which nobody can rebel and whose truth nobody can deny or fail to recognize. The glorious heroes of the epoch of war such as Hector or Achilles accepted its course, as indeed did the pained but unbowed victims of the tragedies, and more precisely figures such as the Antigone of Sophocles or the Medea of Euripides.

Why, then, so much solemn rigor and strictness in relation to abortion? In reality, there is no contradiction at work—the destiny of death is endured almost as the other side of the coin of glory and fortitude; abortion, on the other hand, is looked for and the outcome of free will. The first follows nature and is thus accepted, the second is against

nature and is thus condemned. What is of crucial importance in determining its unforgivable seriousness (hence the reference to the sacredness of the Hippocratic oath) is the fact that the person who commits it is precisely that person—the physician—who is the steward of life because he is an expert on nature and thus a scientist of man.

The reference to nature which is essential to an understanding of the Hippocratic message requires, however, further investigation. This enables us to understand in what ways nature is invoked in the oath and why it forms the basis of that oath's morality. It is evident that in the culture of Western modernism the term "nature" either, on the one hand, describes a purely passive or neutral reality which is to be disposed of according to the will of man or, on the other, portrays a negative reality which must be fought.

In classical culture, however, "nature"—as a word, a concept, an entity, and in terms of sensibility and sensitivity—has a strong and positive value and significance. From all these points of view nature models the *whole* of the world: that anthropocosmic global universe the knowledge of which constitutes a guarantee of integral truth. This is because what is involved is a knowledge of *everything* through various component parts and not through parts which are not connected to each other or disjointed. A truth, therefore, which is overall in character, within whose framework the truth about man becomes understandable, and more specifically the truth about man in relation to the characteristics and properties which are specific to him. For this reason, in the analysis of the truth concerning the understanding of this "everything," science and philosophy cannot be distinguished. They are, instead, brought together in the term *epistéme* which is at the opposite pole to the false science of opinion.

It is symptomatic of the understanding of the unity of knowledge that the truth of the complicated and highly intricate anthropocosmic universe—which is reached through a unitary and unifying *epistéme*—is expressed through what are termed "laws." This term has been valid for centuries both in relation to the regulating laws of the physical and animal world and in relation to the fundamental and not arbitrary laws of the human world. And it is by no means accidental that the human sector which was considered most bound and linked to law and to legality (even though in actual fact it was much more arbitrary), was in that culture always the sector of politics, of power. The "Good Life" proposed by Aristotle for the political community was based upon "government by law" and not upon submission to "government by men."

An old testament biblical text of seminal impact enables us to understand how the strong classical sense of nature continued to exist, albeit in changed form or rather in a different

form, through the centuries of Judeo-Christian cultural molding. In the Book of Wisdom the creationist principle is expressed in a way which is of especial significance for our inquiry and analysis. The inspired writer presents the following sentence: "All things...are yours, O Lord who *love* the living. For your immortal spirit is in all things" (Wisdom 11:25-26 and 12:1).

It may be said *per incidens* by the philosopher that I am and not by the theologian that I am that modern science has demonstrated the fallacy of the ancient and classical idea of the eternity of matter (and thus of the presumptuous affirmation of Laplace). Today's scientist well knows that the journalistic "Big-Bang" is at the origins of that which is *measurable* by the highly modern chrono-spatial measurement of space and time. But it is not the origin in itself—it is itself the product and outcome of further origins.

We are not returning here—and the point should be underlined—to the ancient lack of distinction between scientific knowledge and philosophical knowledge. This would be an ill-advised endeavor because of the great distance which has now grown up—and rightly grown up—between these two areas and their separate methods: on the one hand empirical methods of observation in the formation of hypotheses, and reflective introspection about man in himself and in his social projections on the other.

We are dealing rather with grasping the fact that in both spheres of inquiry and knowledge the same subject is always present and at work, namely *investigating* man, a being who is always searching in both fields for certainty and truth. *This* man is not satisfied by partial knowledge but is aware of its limitations—he thus seeks *complete* knowledge. This is something which he needs. But this need is not the special prerogative of scholars and men of learning, whether they are scientists or philosophers. Even the most ordinary of men feel this need and respond to it, albeit in simple, ingenuous and imaginative fashion, doing so in a "wild state" to employ the phrase of Lévi-Strauss.

Investigation, therefore, is the special characteristic of *living man.* This latter is thus the unifying and shared source of the anxiety, the need, to know. Knowledge which is indefinite in its origins but which is to be found placed between two poles the most rigorous forms of science on the one hand and the most penetrating forms of philosophy on the other. From this point of view we gain sight of the special figure of man, a figure which is at first sight of a paradoxical character and nature. Indeed, man is *in* the world, lives by the world and cannot live *outside* the world. But at the same time he is *beyond* the world because of his ability to understand the world, to interpret it, and to judge it.

However the paradox is only apparent, an appearance created by

that philosophy which seeks to deny that man has his own special nature and asserts that he has a nature which merely goes on mutating. "Man does not have a nature, he has a history" is the emphatic and peremptory declaration of Ortega y Gasset, a declaration which perfectly expresses the thought and outlook of idealism but which also reflects modern empirical pragmatism and more in general anti-metaphysical thought. In reality, this special participation in the world and at the same time this being beyond the world is the specific and characteristic *nature* of man and brings out the specific and characteristic ways and forms by which he is present within the world.

The whole of major Christian philosophy is aware of this and has always understood human nature in this sense and not in a merely biological-naturalistic sense. But here in this august assembly I think it would be more suitable to quote the lucid testimony of one of the greatest philosophers of our time—Ludwig Wittgenstein. In his *Tractatus Logico-Philosophicus* (in German!) we find the following statement: "The meaning of the world can only be found beyond it" (*Tract.*, 6.41). This statement is argued with a happy combination of rigorous formal logic and penetrating empirical observations. "Beyond the world" is certainly God for Wittgenstein as well. As a philosopher he designates this as being *das Mysteicke*, the Mystical, in relation to which man can understand the world as being reality made up of "delimited totality" (*Tract.*, 6.45). Very recent astrophysics is convinced of the same thing. Man, therefore, by his *very nature*, is within and outside the world because his knowledge enables him to determine its limits.

The paradox which I have cited, namely *"Primum philosophari,"* now appears as a very simple, even banal, truth. In order to live we must understand life and to understand this we must understand the *nature* of man in his bivalent relationship with the world. For this reason we must begin with philosophy, but from that form of philosophy which does not repudiate nature but accepts that it is a fertile terrain for investigation.

And a renewed philosophy of nature enables the philosopher, and above all the medical doctor, whether scientist or practitioner, to meet and to cooperate, because they are united in *taking care of* man in his overall unity. It is precisely in the act of care that both understand and perceive (indeed they must understand and perceive) that they can become fulfilled men through an integration of scientific knowledge and philosophical knowledge, in an act of dedication to man which, at root, is love.

Professor SERGIO COTTA
Professor of the Philosophy of Law at La Sapienza University, Rome
President of the International Union of Italian Catholic Jurists

ROBERT C. GALLO

AIDS as a Disease of the Body and the Spirit

Your Eminences, ladies and gentlemen, I thank Cardinal Angelini for his invitation and for the privilege of being here to speak to you and to learn.

The topic I was asked to address is AIDS as a disease of the body and spirit. The former is relatively easy; the latter is open to several interpretations. My perspective will be from the view of a biomedical scientist.

We arrive at the end of our millennium with knowledge of and pride in the great achievements of medical science in this century. This is true and the pride justifiable. However, these achievements, this pride was over-extended sometimes to the point of arrogance. During the 1970s it was not so uncommon belief in some western medical centers that infectious diseases were "passé." The serious ones for us were all "conquered." Serious infectious diseases were only a problem for the "third world." Indeed, some prestigious medical schools went as far as abolishing departments of microbiology. Confidence was high. But microbes have been with us since humanity began, and will continue with us to the end. At this very period the AIDS virus, like a lion on top of its prey, had already leaped from the rain forest, viciously, unexpectedly, fiercely making its presence felt. By 1981 the first causes of AIDS were diagnosed in the U.S. and by 1982 the realization that a great new epidemic or pandemic was at hand. In fact, AIDS was destined to be the contemporary plague.

What are the lessons? The first and most obvious one is the reminder that great epidemics come and go, often unexpectedly; epidemics of the past have often disappeared for a few centuries without the great advances of modern medicine, only to return just as unexpectedly. In short, medical science must remain humble in the presence of nature, and remember that microbes have always been with us from the beginning and will remain with us to the end. The second lesson, related to the first, is that though we may divide the world into economic orders, such as "first world," "second world," and the far more frequently used phrase "third world," the microbial world the world of viruses is increasingly becoming one. Moreover, the prior attitude that such diseases were only limited to far away places, not for "us," was a striking example of social arrogance and one which flies in the face of the theme of this meeting.

What is the origin of the AIDS epidemic? First, we need to consider the origin of the viruses. Biomedical scientists have convincing evidence that the AIDS virus (HIV), like most of life, originated in the African rain forests, and may have entered humans many times from monkeys which are often used as a food source. One suspects that by cleaning such food many opportunities for infection could occur by accidental wounds. Though this probably happened many times in the past, we are all aware that the epidemic is recent. The first cases were discovered in the U.S. in 1981, and these patients were likely infected in the 1970s and possibly earlier. Early infections in the African rain forests were probably rare, random, with the infected trying alone with the disease. From social studies I suspect the beginning of the epidemic occurred in the decades post-World War II, when colonial powers left central Africa. People had not learned well the new ways and perhaps forgot the old ways. Coupled with outbreaks of tribal warfare, significant migration occurred from country-side to city. This was associated with increased prostitution. The rain forest had come to the city.

Global major social changes also occurred in the decades after World War II. The enormous increase in air travel and sexual promiscuity, the nightmare development of intravenous drug abuse as a way of life for many, and the medical use of blood (transfusions) and blood products going from one person to another and even from one nation to another ensured that a rather difficult-to-transmit virus, once rare and remote, could rapidly become common and global. The rain forest was now everywhere.

What is the status of the epidemic now? I do not keep a very close eye on the monthly figures. I repeat what most epidemiologists say: that by 2,000 we will have some 30 to 50 million infected people. Everyone knows of the devastating effects of AIDS on many African countries and of the recent great increase in infected people in some Asian nations. My colleague, Dr. Robert Redfield, recently told me that the average age of death of a man in Uganda was 46, but now because of AIDS it is 37. There are many other appalling statistics.

Who is now infected? The greatest rise is in women, infants, and the poor.

What is the *future* of the epidemic? Because the epidemic is still in flux, it is not easy to predict. Further, the transmission of HIV is facilitated by the presence of other venereal diseases, and who is able to predict the future of human habits? We also have some important new results from our friend Dr. Max Essex, Director of the Harvard AIDS Institute in Boston, which

lead us to be concerned about possible rapid changes in the nature of the epidemic depending upon the entry into a population of special strains of HIV. He found that HIV strains dominant in Asia and Africa are much more able to infect cells of the surface of the female vagina or male urethra than the dominant strains in America and Europe. Therefore, the Asian and African strains are probably much more transmissible by heterosexual sex. It is possible that such strains will soon come to Europe and the Americas.

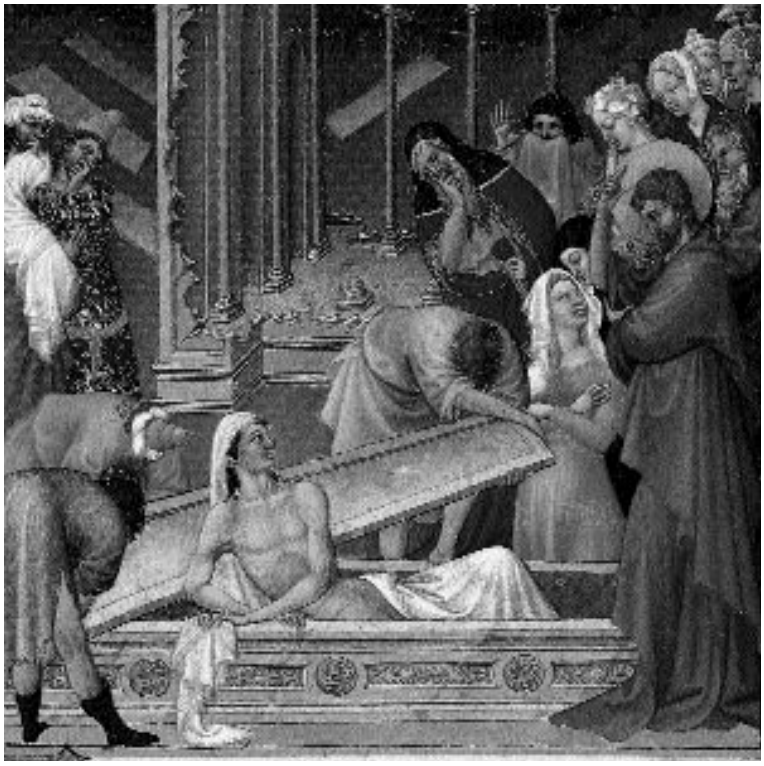
How important is AIDS compared to other diseases? Not infrequently I hear statements such as: so many more people die with heart disease or from cancer, etc. This is a question we must respond to with great care because it is a useless exercise for medical scientists to compete for their "favorite disease," and the response must not intensify such feelings. Simply put, we can say that AIDS is new, still increasing, usually affects the young, causes as much or more suffering and over a longer period of time than any known disease, wrecks families, has undermined entire nations, makes many other diseases much worse, and can allow for the development of other epidemics caused by other microbes (consider the return of a more virulent tuberculosis). Research in AIDS has direct relevance to many other diseases.

What can we briefly say about AIDS as a *disease of the body?* Simply put, probably AIDS produces as much suffering or more than any known disease. Patients become emaciated; infected with innumerable other microbes because of the incapacitating effect HIV generally will finally have on the immune system, microbes which can sometimes disfigure the person; the brain is infected by HIV, and this can lead to psychological problems as well as neurological changes; and certain cancers develop. Needless to report here, there is also the fear of the suffering, the economic ruin, the loss of social contacts and death.

What can we say *about blame* and the various "risk groups"? Should we blame the infant infected from his or her mother? I think not. Should we blame the woman infected by her husband? I think not. What of the prostitute? I do not believe most necessarily freely choose this type of work but can be driven to it from poverty, drugs, or an unfortunate family background. Should we blame her? I think not. We come closer to what is often perceived as the difficult issue, that of the homosexual.

AIDS as a disease of the spirit was also a topic assigned to me. Many individuals are more qualified to discuss this than I am, particularly those in the "front lines" of the disease—those who give primary care to the dying, those that help the individual endure the chronic suffering, etc. This includes, of course, those Catholic hospitals that provide the bulk of such care, as we see, for instance, in New York City and in many underprivileged countries. As

a scientist and as an individual who has now known several such patients, my observations suggest that the biggest sickness of the spirit in AIDS is despair and fear despair and fear, of being prejudiced against, of being judged, of financial ruin, of loss of family, of possible loss of job, of being avoided like lepers of the past, of family destruction, of suffering, of death. Sometimes these feelings are transformed to guilt or hate or rage.



AIDS as a *disease in need of all society*. I do not know of any disease so dependent upon so many segments of society. Obviously, there is continued need of the primary health care professionals—the nurses, physicians, paramedics, and administrators who make hospitals and hospices work. There is the constant need of involvement of the educator. There is the need of family and friends, of political support and leadership, of substantial financial investment from society over a period of years, of many kinds of scientists, of organized bodies perhaps in particular the Church.

I will end these brief comments on a positive note. I believe that at the end of 1995 there is *some good news*. First of all, it is my impression that there is indeed a marked improvement in understanding and concern by society as a whole (though I am still sometimes concerned by complacency in some quarters). Second, the slow and steady gains made from basic scientific studies of this disease and its virus are beginning to open doors for what may very well mark the beginning of the end of AIDS as the incurable horrible disease. The possibility that HIV infection can be manageable and that a person may be able to live well with HIV seems to be at hand. There are several reasons for this. First, there is the relatively new information that a subset of HIV infected people, albeit a small fraction, live long and well. Consequently, there is new confidence that bringing this condition under control is possible. Second, recent clinical results in which two or more drugs which target HIV were combined produced far more impressive suppression of HIV than one alone.

Third, a consensus in the research field is emerging, indicating that early and "hard" anti-HIV therapy is the correct approach. However, these approaches involve chemicals which can be toxic when given over time. We are working on some new approaches which utilize biological approaches against HIV, approaches which may be minimally toxic or not toxic at all so that their administration may be long term, as life long therapy against HIV well very likely to be required. We will make better therapy against HIV the primary goal of the new Institute of Human Virology at the University of Maryland in Baltimore.

Professo ROBERT C. GALLO
Director, Institute of Human Virology,
Medical Biotechnology Center,
University of Maryland at Baltimore
USA

GOTTIEB MONEKOSSO

The Integral Training of the Physician for Care of the Sick

The Good Samaritan was not a physician. He was a caring citizen. Medicine is a caring humanitarian profession. In the past few decades however, the rapid growth of science and technology has virtually transformed physicians from the classic profile of humanists to that of competent technologist. Global political, social and economic changes have also shaken the foundation of medical ethics this century. We hope that the twenty first century will restore the balance between technology and humanism in medical practice.

1. Crisis and Change in Medical Education

Medical schools currently overemphasize the acquisition of biomedical scientific knowledge. Little attention is paid to professional attitudes; furthermore, because of super specialization, skills are fragmented and the majority of practising physicians focus on disease entities rather than the sick person.

Students and teachers of medicine world wide are increasingly conscious of current distortions from the Hippocratic tradition and the spirit of caring exemplified in the parable of the Good Samaritan. There is a global movement for change, a search for quality medical education under the leadership of international organizations, especially the World Federation for Medical Education.

Recent changes in the organization of medical care and health services have resulted in the diminution or loss of "caring". Medical schools everywhere must now face the challenge of restoring the "care" to medical and health care. They must aim for the highest possible globally acceptable professional standards; through a reform of basic medical education, which would be reinforced by postgraduate and continuing education programmes. There is a need to coordinate and integrate the large number of disciplines and specialties which to into the makings of a doctor of medicine. This is probably best done by describing the behaviourial characteristics or profile of the model student at the end of the prescribed period (years) of medical studies.

2. Profile of the Competent and Caring Physician

The physician would demonstrate problem solving capability identified as *Professional Thinking;* this would be associated with clearly identifiable *Professional Attitudes*, combined with a range of psychomotor abilities described as *Professional Skills;* he/she will also be a living encyclopaedia embodying a well integrated "informationn base" - *Professional Knowledge*. The sum total of these behaviourial characteristics would bve the goal of integral training of the doctor. These elements would be crystallized around Medicine's central theme - *Clinical Methods*; i.e. taking the history of a patient's illness, select and interpret results of investigations, give advice on treatment, rehabilitation and prevention; educate the patient, family and community; work "in healt centres or offices" with other health team members and manage a local health service for the benefit of the community.

3. Professional Thinking and Problem Solving

Professional thinking typical of a competent physician, has been described as critical reasining, evidence based medicine, clinical decision making and problem solving capability. These characteristics are generally derived from the study of a number of scientific disciplines applied to medicine - *The scientific basis of medical practice medical practice.* The most important of these are Anatomy, Physiology, Pharmacology, Biophysics, Biochemistry, Pathology, Microbiology, Immunology, Histology, Embryology, Parasitology and Entomology. It has been suggested that these can be crystallized in a few key disciplines. Professional thinking can be reinforced by reviewing clinical physiology, clinical pathology and clinical pharmacology.

4. Professional Attitudes: Humanism and Caring

Caring for the sick and unjured, equal consideration for all persons, consciousness of economic costs to patients, adapting to different socio-cultural environments, awareness of his/her own limitations, and a deep ethical respect for life - these are some of the professional attitudes expected of physicians. They may be inculcated or acquired through the study and application of a number of disciplines which focus on the physical, men-

tal and spiritual well being of people; as individuals, families (households) and communities. These disciplines Ethics, Anthropology, Sociology, Psychology, Demography, Genetics, Economics, Management would provide the *Humanitarian basis of medical practice.* It has been suggested that these can be cristallized in a few key disciplines. Professional attitudes can be reinforced by reviewing health care ethics, health care sociology, health care economics.

5. Professional Skills Broad Clinical Abilities

Medical students acquire many skills during basic medical education, and these are generally further developed during the exercise of medicine. Skills are however highly fragmented in a wide variety and a large number of specialties. Integral training can however be assured by organizing for medical students practical "hand on" experiences in three main areas.- patient care skills, reinforced by laboratory/investigative skills and community management skills. These are the *Professional skills for medical doctors.* Patient care skills are strengthened by working in clinical medicine with paediatrics, geriatrics, psychiatry; in clinical surgery, and surgical specialties; and in obstetrics and gynaecology. Laboratory investigative skills are acquired by working in clinical pathology, clinical radiology, and clinical investigation units. Community management skills would be developed by working with and learning from people during practical assignments in community health, health statistics, health planning and management, healt care financing, and working with community groups e.g. in health committees, development committees, and participating in community/household surveys.

6. Professional Knowledge Basic and Integrated

Professional knowledge has expanded rapidly with the growth of science and technology. Medical educators need "to crystallize" essential knowledge for medical practice. This has been summarized in three major themes as recognition of ill health, management of ill health, and prevention of ill health in individuals, households and communities. *Professional knowledge for medical doctors* is presented in a bewildering array of disciplines but can generally be classified in the above three categories:

– *recognition of ill health:* Medical, surgical and gynaecological pathology and related disciplines

– *management of ill health:* Medicine, surgery, obstetrics and gynaecology, paediatrics, geriatrics, psychiatry etc.

– *prevention of ill health:* Public health and related disciplines; epidemiology, nutrition, environmental health, maternal and child health, occupational health, and disease control.

7. Quality Medical Education

There is a dire need for physicians oriented to the overall care of the sick person, his/her household, his/her community, and whose profile is in keeping with the above behaviourial characteristics—Physicians, family physicians, community physicians whose main role would be to care. These physicians would have a *Quality medical education.*

They would also be capable of teaching other health personnel and undertake quality health research, in the art and science of healing the sick. It has been suggested that quality (a difficult characteristic to apprehend—it is in the eyes of the beholder) depends upon two apparently contradictory variables—excellence and relevance. A medical school and its graduates can be appreciated by the scientific community (excellence) and the local community (relevance). The world's medical faculties and their individual departments can probably be characterised as dedicated to the pursuit of excellence, dedicated to the pursuit of relevance, and those that are achieving quality (of care) by combining excellence and relevance.

8. Combining Science with Humanism

A strong scientific background with emphasis on the application of science and technology will help to ensure problem solving professional thinking. The acquisition of skills and knowledge would make it possible for the problem solving physician "to do something" and demonstrate his/her capacity to "care for the sick". But, in the final analysis, it is the physician's professional attitudes that would determine to what extent, to what degree these skills and knowledge benefit the patient. In other words the degree of caring. As in the parable of the Good Samaritan does the passer-by continue his journey without stopping, or does he go the whole way, and even commit his resources on his return journey. Nevertheless, even the best intentions, the most desirable professional attitudes would be inadequate in the absence of professional thinking (problem solving capability). The scientific and the humanitarian bases of medical practice must go hand in hand.

9. Renaissance of Humanism in Medicine

The World's faculties of medicine have accumulated considerable experience in the teaching of biomedical science; the second half of this century has seen the devaluation of medical humanism; and with it a significant drop in the role and the place of physicians in society. An important challenge for medical schools and the medical profession in the 21st century would be to bring back the pendulum. For this reason further consideration of integral training of the physician will focus on the teaching and conscious inculcation of desirable professional attitudes. In this area role models are important - an ounce of "example" is worth more than several pounds of "predicating". Teachers of medicine significantly influence the behavior of their students, and the manner in which medicine is practised in a society will determine how medicine is taught.

10. Cultivating Humane Attitudes

From a pedagogic standpoint prerequisites for entry and the methods of selection of students are important. Current methods favour cognitive functions. But assessment of non-cognitive functions and the quality of school or college experiences are also looked into; especially the candidates participation in extra-curricular activities. Assessments of character and socio-cultural background are sometimes attempted. And once in medical school the student's progress in attitudinal development should be monitored alongside growth in problem solving, skills and knowledge. A number of themes on the humanitarian basis of medical practice would be integrated into the core activity of a practising doctor's life - *Clinical methods*. Some of these themes follow.

11. Caring for the Sick

Caring for the sick, concern for people, willingness to help others (going out of one's way, like the Good Samaritan), being accessible to people, a friendly welcoming disposition; caring comes before money or any other consideration, handling persons with care—respecting their autonomy, respecting confidentially of the doctor/patient relationship, interest in the person's life situation not just "an interesting case", and providing continuing, integrated total care of the whole person. This caring includes acquiring some of the attributes of a good nurse.

12. Community Health Concerns

Extending caring to the person's household and community; people centred care with a focus on the person's life situation - infant, child, adolescent, youth, adult, senior citizen; community based care organized for family/household members in defined communities (rural villages, city blocks) such as in health centre practice or office practice, with involvement of community leaders, community councils; locally managed health care of community based activities, district/local health planning and management, health information, community health financing; supplies of essential health commodities (e.g. drugs and vaccines).

13. Awareness of Professional Limits

Awareness of his/her own professional limits and capabilities as a physician, as well as the operational capacity of the hospital, health centre or institution to which he/she belongs, adapt to this operational capacity, refer patients to better equipped centres and to appropriate specialists and services. Awareness of professional limits would be helped by feedback from teachers and peers, journal clubs, tutorials and discussion groups etc. Students would be advised to keep a diary of their experiences.

14. Equity and Social Justice

Equal consideration for all persons, male or female, high, middle or lower class; independent of race, religion, tribes/class, wealth, country, province or district of origin. There should be special consideration and care for special groups—drug addicts, alcoholics, sex perverts, *Hiv/Aids*, etc. The student and practitioner will consciously attempt to identify his preconceived or unconscious discriminatory tendencies and endeavour to overcome them.

15. Awareness of Costs of Health Care

The physician should be fully aware of the costs of health care to the patient, his relatives, friends and household; and indeed to the community and nation. It is an extension of the caring for the sick—the economic costs are not only financial, but loss of time from school and work, with consequent loss of productivity; loss of opportunities for interpersonal and family relationship.

Physicians are aware that poor people are more frequently ill and often more severely so. The burden of sickness is higher in poorer countries.

16. Adapting to Different Circumstances

Physicians learn to adapt to varying socio-cultural environments. Their first challenge may be the language, culture and people around their medical school. The local language is vital in clinical practice. Solving the prevalent local health problems is the first step to national and even international renown. Adapting to a local or national culture is a major step towards the capability of performing efficiently in another country if called upon to do so. Physicians should master at least one of the major international languages.

All these call for "open mindedness" ad a willingness and humbleness to learn, and continue to learn many things - apart from biomedical science.

Adapting should, however, not mean lowering professional and ethical standards.

17. Ethical Respect for Life

Profound ethical respect for life takes us into the depths of health care ethics; it begins with equal consideration for all persons and respect for the autonomy of the individual. It embodies the well known principle of doing no harm *(premum non nocere)*. Changes in social behaviour (or what is acceptable social behaviour) and developments in technology now impose on each and every physician the need to fully apprehend and take responsibility in the domain of ethics.

Abortion, euthansasia, care or sacrifice of severely disabled newborn children, care or otherwise of the mentally ill, transplantation of tissues and organs (donor, recipient, physician relationships), invitro procreation (test tube babies etc.), dying in dignity, none participation in torture, not to mention the rapidly growing impact of ge-

netic engineering on medical practice. These complex questions cannot be taught through abstract case studies but reviewed as they arise in the course of day-to-day professional experiences alongside biomedical issues.

Conclusion

Integral training of the physician for care of the sick we believe will require the reorientation of medical education programs along the lines proposed here. Teachers and learners alike should ensure that while observing the trees in detail they do not lose sight of the countours of the forest. We believe that all medical schools can set themselves a goal of producing physicians that are GLOBALLY COMPETENT AND CARING. It will not require a major reorganization or restructuring of any medical faculty. It will require, however, a fundamental acceptance by teachers and learners alike that medical schools exist first and foremost for the integral training of physicians for care of the sick.

Pr. GOTTIEB L. MONEKOSSO
Emeritus Regional Director for Africa of the World Health Organizations, Cameroon

FRANCISCO EDUARDO TRUSSO

Medicine and Christianity

The title of a previous international conference has already supplied us with a definition of how the Christian should understand the concept of life: *Gloria Dei Vivens Homo* ("The Glory of God is Living Man").

In the Bible we can see that the psalmist repeatedly returns to the idea and conviction that life is a special blessing of the Lord:

"The dead do not praise the Lord,
nor do any that go
down into silence,
But we will bless the Lord
from this time forth for evermore."
(Psalm 115)
"Precious in the sight of the Lord
is the death of his saints."
(Psalm 116)

"I shall not die, but I shall live,
and recount the deeds of the Lord,
The Lord has chastened
more sorely,
but he has not given me
over to death."
(Psalm 118)

At the same time a life which lasts long enough for the just man to see the children of his own children, the third and fourth generations, is considered a blessing of the Lord by the authors of the psalms.

But the bible does not only speak about death as an evil and life as a blessing it also holds the same opinion about illness. Indeed, the psalmist calls on the Lord to restore his health so that he can then give thanks to the Lord for his release from illness:

"Some were sick through
their sinful ways
and because of their iniquities
suffered affliction;
their loathed any kind of food,
and they drew near to
the gates of death.
Then they cried to the
Lord in their trouble,
and he delivered them from
their distress;
he sent forth his word,
and healed them,
and delivered them from
destruction." (Psalm 107)

"Afflicted and close
to death from my youth up,
I suffer your terrors;
I am helpless.
Your wrath has swept over me;
your dread assaults destroy me."

"Every day I call upon you,
O Lord;
I extend my hands to you.
Do you work wonders for the
dead?
Do the shades rise up to praise
you? (Psalm 88)

And the psalmist also speaks through the mouth of the man who has been healed and through the mouth of the just man who lives out his long life in good health:

"The righteous flourish like
the palm tree,
and grow like the cedar
in Lebanon.
They are planted in the house
of the Lord,
they flourish in the courts
of our God.
They will bring forth fruit in
old age,
they are ever full of sap and green." (Psalm 92)

The subject of medicine and medical doctors is also given extensive consideration in Holy Scripture. Indeed, in *Ecclesiasticus* (38:1) we can read:

"Honor the physician with the honor due him, according to your need of him, for the Lord created him; for healing comes from the Most High, and he will receive a gift from the king. The skill of the physician lifts up his head, and in the presence of great
men he is admired. The Lord created medicines from the earth, and a sensible man will not despise them... And he gave skill to men that he might be glorified in his marvelous works. By them he heals and takes away pain; the pharmacist makes of them a a compound."

In addition Holy Scripture provides guidelines by which to treat illness and the Lord is called upon to provide medicines which will achieve a cure:
"My son, when you are sick do not be negligent, but pray to the Lord, and he will heal you. Give up your faults and direct your hands aright, and cleanse your heart from all sin... And give the physician his place, for the Lord created him; let him not leave you, for there is need of him. There is a time when success lies in the hands of physicians, for they too will pray to the Lord that he should grant them success in diagnosis and in healing, for the sake of preserving life."

During the first centuries of Christianity there were on the one hand the anchorites who withdrew from the world in order to devote themselves to the glory of the Lord in so doing they placed themselves entirely to the hands of God. On the other hand, and in similar fashion, there was also a certain asceticism which despised everything which was associated with the body and perceived in illness and the neglect of the body a kind of blessing of the Lord. This way of thinking and behaving was paralleled and matched by a total repudiation of human culture and by an exclusive dedication to thinking about, and reflecting upon, theology and the Holy Scriptures. Care for the culture of the spirit and the body was associated

with a pagan attitude and approach.

This belief, which bore the influence of Plato and the agnostics, was not shared by the principal Fathers of the Church and failed to leave a major mark on Christian traditions. In opposition to Plato, who believed that the body is the prison of the soul to which it is bound as a form of punishment—as a result of which the body is an obstacle to the achievement of complete virtue, Christianity offered the Tertullian concept of *caro cardo salutatis* ("the flesh is the cornerstone of salvation"—from *Resurrectiones Carnis*, 8). This is an idea which is at the very center of our faith and expressed in the concept of the "Word made flesh."

St. Irenaeus provided the words which form the introduction to this paper but also coined the famous phrase: "caro possidere in regno a spiritu potest" ("the flesh is possessed of the spirit").

This principle lays down that the body should be cared for with personal hygiene, with rest, with useful and controlled activity, and through avoidance of those forms of activity, those foods, and those kinds of lifestyle which destroy the body or which seriously endanger its health. It is interesting to observe in relation to this point that St. Thomas Aquinas suggested that the taking of a bath in the evening was an effective means by which to treat "sloth" or sadness, the condition which we now term depression. This holy theologian believed that such specific forms of treatment for the body were a means by which to achieve the overall health of the human spirit.

At the beginning of the evangelization of Latin America the Councils which were celebrated in that continent were already prescribing concern for health, personal hygiene, suitable rest and physical exercise, and the maintenance of healthy and salubrious homes, in their advice to the native populations (see the Councils of Lima and of Quito). The missionaries in America dedicated themselves a great deal to the study of medicine, and examined medicines and medical techniques practiced by the local inhabitants in addition to those which were being developed at the same time in Europe.

In Christian liturgy it is made clear that the sacrament of the Eucharist is sustenance for the spirit and for the body. Furthermore, one of the seven sacraments is specifically reserved to the anointing of the sick. This sacrament is seen not only as a stage on the journey to the next life but also as a specific form of treatment and therapy. It is for this reason that emphasis is placed upon the fact that this sacrament should not only be given to sick people who are in danger of dying it should also be given to those people who are suffering from illness and who want to recover and regain their health through the sacrament of the anointing of the sick.

In the gospels it is repeatedly observed that Jesus performs his ministry by healing the sick. We should not see this as being merely an example of the use of miracles by which Christ demonstrates his divinity and the power of the Father. It is also an expression of the concern of the Son of Man for the health of his brethren. The fact that Jesus wept on hearing of the death of Lazarus is a good example of this.

Christianity believes that the ultimate goal of man is supernatural life—that time and condition when there will be a glorious resurrection of physical bodies. For this reason Christianity is not afraid of sick, handicapped, wounded or suffering bodies. On the contrary, Christianity takes care of them and is concerned about them in very a special way.

Following the principles of its earthly teaching, our religion has taken care of these bodies and has dedicated much of its activity to the bringing of comfort and help to them. It naturally sees an evil in illness and in malformation but this is not an absolute evil which must be distanced at any cost and with disdain for questions of humanity and morality. Christ said to the paralyzed man: "Rise up and walk!" and he also said: "Whoever wants to be my disciple must take up his cross and follow me." The cross is our body with its pains and its illnesses, and these are the means by which we unite with his redemptive action.

The evident dualism between what Christianity proclaims about the need to keep the body in a state of beauty and in health through suitable stewardship, and what it says about the need for acceptance and patience when we suffer from illness and pain, is an aspect of Christianity which St. Paul sees as imprudence when practiced amongst the pagans and scandal when effected by the Jews.

The parable of the Good Samaritan has always been present within the teaching of Christianity, not only with reference to acts of charity but also as a subject for study and research in the development of science and of technology in the widest possible sense of these terms.

The informed consent of the patient, the relationship between medical treatment and the destiny and future of the patient, the limits in the use of methods and instruments by which to defend life and health, the techniques of intensive care, euthanasia, the limits to the application of various kinds of therapy, and all the rest, are subjects which have been considered and debated by Christianity and which are at the present time discussed by the world of medicine.

In a large number of speeches Pius XII dwelt upon these subjects. Especial reference may be made here to his address on the subject of a number of questions relating to new methods of intensive care which was delivered on November 14, 1957. The Congregation for the Doctrine of the Faith has dedicated great attention to the subject of euthanasia. Also of importance here is the article by Manuel Cujás S.J. entitled: *"The Rejection of Treatment."* In another work this author makes the following observation: "Health and life, thought about in organic and psychological terms, are not the final goal of moral behavior. They are a means whose importance should be judged in relation to its effectiveness in reaching an individual's perfection and destiny. This is what we were created for and it is the high-point of the plan for each individual's life. Moral theology has always produced and formulated suitably precise concepts by which the individual can place limits both negatively and positively to his freedom in the honest organization and direction of his life and his psychophysical integrity."

In the address which has been mentioned above, Pius XII placed limits to the duty to defend life and health. He stressed the need to employ only conventional and usual methods and means and to leave the use of other instruments to the decision of the sick person, ensuring at the same time, however, that he is fully aware of the conditions and circumstances which surround such a decision.

His Excellency
FRANCISCO EDUARDO TRUSSO
Argentinian Ambassador to the Holy See

ELIO TOAFF

Judaism

The title of this Conference, *"From Hippocrates to the Good Samaritan,"* presents me with certain difficulties. The name of Hippocrates takes us back to the beginnings of the Western tradition of medicine and to the Greek codification of the first tenets of professional ethics. But the character of the oath itself, which bears the name of Hippocrates, is still limited by an initial idolatrous invocation and by certain worries about the secret of the transmission of the doctrine and the practice of the profession. The name of the Good Samaritan, on the other hand, is seen at the level of common use as the symbol of dedication to taking care of the sick, of a love which rises above national and religious differences, and which sees the sick person, whosoever he or she may be, as simply a human being to be helped.

However, the parable of the Good Samaritan, as it is expressed in Luke 10, bears the signs of a polemical laceration which seems to affect Judaism directly. At that time, as today, Jewish society was divided into three estates: priests, Levites and ordinary Jews. In the parable the priest and then the Levite refuse to help the wounded man. A third person, the Samaritan, then intervenes; a person who belongs to a different community and provides a great lesson in humanity. In the parable, therefore, one figure is conspicuous by his absence—the ordinary Jew is not there. It has been suggested that the original version of the story spoke about this figure, but as the facts stand, the official text refers to a Samaritan. One of the possible morals of the story is that it is necessary to go outside Israel to find humanity and solidarity. Thus it is that the great message of the parable regarding love and solidarity without distinctions between men is contaminated by an underlying bitterness—a great deal of love is preached side by side with a touch of hostility. Here, while I give thanks for the invitation to participate in this important conference, I would like to emphasize that my role is to speak in the name of the person who was absent in that parable, in the name, that is, of that ordinary Jew who would not have been able to study medicine in the temple of Hippocrates, and who in the parable of Luke is not even considered as a possible source of acts of charity.

Hitherto I have spoken about the limits of the models to which this conference refers. But I am even more convinced that the authentic meaning of our discussions should lie in defining with a full consciousness of the lack of comprehension of the past—a road which we can all take in the service of man and especially in the service of those who suffer. We need to perceive the great insights of progress in the models of the past, find their cultural and religious roots, and place them at the service of all men.

Taking the parable of the Good Samaritan as a point of departure, I would like at the outset to emphasize three points. The first concerns the criticism leveled at the priests. A Talmudic text (Joma, 23a) relates—and almost with horror—an account of priests who had stabbed each other in the Temple over a question of precedence during the religious service. The rabbinical comment on this event (which was contemporary, if not prior to the parable of the Good Samaritan) is that for some priests technical questions of ritual purity were more important than human life, even the life of the sons of the priests themselves. This commentary amounts to a sad and self-critical description of a religious world which perceives the limits and the risks of ritualism and juridical "technicalism," even though it certainly sees ritual and law as constituting essential elements in religious life.

A healthy and alive religious system must have this criticism before it at every moment. Judaism has done this from the age of the prophets, and has never ceased to do so, through its most inspired masters. But as was clear from ancient times, and is still clear today, the question (which is of great importance) is certainly not a matter which concerns merely the priests of a religion. A priest is not only a person who has sacred duties: in the etymological sense of the Hebrew word which refers to priesthood, the priest is first and foremost a "servant." For this reason one can say that every society has its priests, its governors and its civil servants who "serve" it and who may forget the fundamental values of respect for human life because of an obsessive respect for the ritualism of their posts. Religions are the first forces to fall foul of the risks of a loss of values, but they are also the first to engage in self-criticism and renewal. They play a key role in leading organized society back to a rediscovery of values.

The second point involves a reflection on the phrase which concludes the parable and is also the title of this conference: *"Vade tu et fac similiter."* The correct behavior of a man is presented as an example to follow. I would like to observe here that within the Jewish roots of this invitation there is a hidden dimension which is much wider and of much greater importance. Not only is there the imitation of a man

who behaves in an upright way, there is also, and above all else, the imitation of God: "You shall be holy," declares Leviticus 19:2, "for I the Lord your God am holy." In the Song of the Sea, in Exodus 15:2, there is written: "this is my God, and I will praise him." "Will praise" in Hebrew is *"weanveu,"* which without vowels can be read as *"aniwahu,"* "I and Him," as if I and Him could be the same.

The Rabbis ask themselves: how can this idea be put into practice? In a very simple way—by imitating Him: "Just as He is merciful and compassionate so shall you be merciful and compassionate" (Shabbat 133b). We can see the same thing in Deuteronomy (13:5): "You shall walk after the Lord they God." The Talmud (Sota) asks: but how it is possible to walk behind the Lord? In practice it means imitating the characteristics of the Lord. In the same way as God visited the sick, as is made clear when the Lord appeared to Abraham amongst the oaks of Mamre (Genesis 18:1) when the sick Abraham was resting at the opening of his tent (he had just circumcised himself), so must you go and visit those who are sick.

As Genesis teaches us (1:26), man was created in the image and likeness of God. This is a difficult concept to understand given that God is absolutely indescribable and cannot in any way be compared to human realities. It is usually thought that the divine image of man is his intelligence. But these teachings rise above, and surpass, this concept. The divine image of man is also to be found in his moral capacities, in the ability to express attributes such as compassion and solidarity, which are indeed human qualities but in fact derive from the divine essence. When man practices these virtues—the *"fac similiter"* with reference to the divine plan—he discovers, revalues, lives and realizes the divine part which is in him.

From here we come to the third point, and perhaps the most delicate part of the overall argument. The individual's obligation to express solidarity and compassion spring from the divine nature which is within us. But from the divine nature which is in each and every man there also springs the sacredness of each human being and of every life, the object of our solidarity. From this derives the biblical imperative: "Love your neighbor as yourself" (Leviticus 19:18), an imperative which is still a challenge for every person. But the dramatic problem—which is indeed discussed in the parable—is the definition of "neighbor."

Can we draw a line within mankind to separate the "neighbor" from the "non-neighbor"? Is it too easy and very mistaken from a historical point of view to think that bad Jews have replied "yes" to this question and the good Christians "no." In truth the question is present within (and constantly divides) religions and institutions, and has the same effect on every society and

every state which today proclaims itself civilized and democratic. The temptation to shut oneself off from others is always and everywhere present. At the outset even Jesus refused to heal a Syrophoenecian woman and wanted to conserve the best part of his forces for Israel alone (which he called child, in different fashion to the term "dogs" he used for those who did not belong to Israel, Matthew 15:21-28, Mark 7:24-30). Every revolution breaks down barriers but it also immediately creates others which are new, different, perhaps greater in number but by no means less problematic from a conceptual point of view. In the place of the circumcised are placed the baptized and in the place of the oppressed are put fellow-citizens or members of the party, and so on.

Here also we must re-evaluate the constructive potentiality of religions: from the common biblical message, the statement of the psalmist to the effect that "the Lord is good to all and his compassion is over all that he has made"(Psalms 145:9), to the Rabbinical teaching which asks why the Bible relates that the whole of mankind descends from a single man and goes on to answer that this is to make us understand that in potential terms each man is the whole of humanity—he who destroys a single man, therefore, acts as though he were destroying the whole world and he who saves a single man saves the whole world (Sanhedrin 5:5). This is a message which Islam has taken up and diffused in identical terms.

And returning to shared biblical roots, we cannot ignore (amongst many examples) the magnificent image at the end of the Book of Jonah. According to traditional Jewish interpretation this is a symbol of the conflict between the attributes of justice and of love, with the last prevailing. The prophet wanted the sinful city of Nineveh, the Assyrian capital, to be punished for its wrongful acts. But the Lord gave the following lesson to Jonah: "You pity the plant, for which you did not labor, nor did you make it grow, which came into being in a night, and perished in a night. And should I not pity Nineveh, that great city, in which there are more than a hundred and twenty thousand persons who do not know their right hand from their left" (Jonah 4:10-11). These ideas should act as qualifying structures for the Abrahamite religions. As the Talmud declares: "He who has compassion for living things clearly demonstrates that he belongs to the line of our patriarch Abraham" (Betzà 32b).

These reflections are the foundation of the religious sense of solidarity in general, and medical activity in particular. If it is true that each and every man is characterized and consecrated by his being made in the divine image, this applies to an even greater degree to the man who suffers. Taking the expression of Psalm 41:4 "The Lord sustains him on his sickbed" as its point of departure, the Talmud (Nedarim 40a) declares that above the sick man and literally above his bed the divine presence is to be found, a presence which cares for him and shares in his sufferings. The experience of the encounter with illness becomes a sacred meeting, *"bidchilu urchimu,"* to use the

a sacred meeting, "*bidchilu urchimu*" to use the expression dear to the mystics: with fear and compassion, with fear and love.

From this point of view, nothing could be further from the idea of seeing the practice of medicine as an activity of pure research or the application of scientific technology. The duty of religions today is to make clear that medicine is an encounter with the sacred, an exercise in what is sacred. Following the arguments and observations which have been made above, the person who works in this sacred area has before him very severe injunctions and warnings.

Priests, who are doctors and health care workers at all levels, must not lose sight of that scale of values which sees human life as an essential reference point and understands that questions of "ritual," technology, and scientific dimensions are mere tools. Whoever has to deal with this area should be aware that the divine dimension of man, and human brotherhood and fraternity, must be recognized and stewarded.

The other great task or challenge which presents itself to the religions of today's world lies in making clear that there must be a set of ethics, a range of rules which can act as a precise guide for behavior and conduct. Every human act must be governed by rules, and this is especially true of medicine, which involves essential aspects of the human condition and which must indeed be seen as a special encounter with the sacred dimension of existence.

The debate over bioethics becomes ever broader in its character, and at times ever more dramatic, as a result of what technological progress can offer. But at the same time we notice that often it is very difficult to reach agreement on a set of regulations in this sphere. Perhaps this is a result of the complexity of the subjects under consideration and the divergence in opinions which exists in this area. We seem to have before us one of the great difficulties of our time, namely a marked slowness in the development of juridical decisions in relation to questions of bioethics but at the same time great speed in the rate of technological advance. This occurs even though there is an awareness on the part of most people who work in this area that there has to be a clear set of legal and ethical rules and regulations in matters concerning bioethics. From the world of technical operators in this area emerge rules of self-regulation precisely because there is an absence of decisions (or because we are still waiting for such decisions) on the part of society and the state.

This state of affairs helps to give a new importance to the tradition of trying to render the ethics of the profession noble, as happens with professional codes of practice. But whilst it is true that the ethical initiatives of a professional category deserve admiration and attention, it is also the case that one feels distress at the slowness which society in general demonstrates in following and developing rules for questions which are so important. But even more can be said. Although it is true that the voice and conscience of health care workers are vital elements in the whole process, it is also important to stress that other voices must not be ignored. If only one group is entrusted with the work of codification—however admirable the intentions of that group may be—then not all needs and ideas are discussed and guaranteed.

I would like to give as an example that which has happened in Italy over the last few months. Given that there is no up-to-date set of rules by which to govern assisted procreation, Italian doctors decided to regulate themselves. The national council of the Federation of the Order of Medical Doctors met on 2 April 1995 and decided to adopt a resolution. This made clear that after vigorously calling upon parliament and the government to produce legislation on the question, it had been decided to establish in the meantime a set of rules for all Italian doctors. Those members of the federation who do not accept these rules are to be subjected to disciplinary measures. When one examines these rules and the principles upon which they are based, certain points and questions emerge which should be discussed in greater detail.

In these rules one perceives that the essential reference point for the evaluation of different options is the well-being of the unborn child. As a result such procedures as "artificial fertilization of women not in a state of early menopause" are forbidden. It is probable that this decision will meet with broad agreement in many

in the Jewish world many rabbis would subscribe to it. But belonging as we do to religions which are based upon Holy Scripture, upon the Bible, we cannot fail to detect a certain contradiction. Genesis describes how Abraham and Sarah, who were both advanced in age and without children, received the marvelous gift of Sarah's pregnancy. We are also told explicitly that Sarah had reached the state of menopause (Genesis 18:11). The child born to the couple was called Isaac and he thus bore a reference to the laugh of the matriarch which was uttered at the news of this incredible violation of the natural order.

Given the technology which is now available, Abraham and Sarah nowadays would have been able to dispense with the need for a miracle, and—paradoxically enough—with today's norms and regulations. He who is the Physician of all living things could today be subjected to the disciplinary measures of the Order of Medical Doctors. But putting jokes to one side, all this should make us reflect upon the inadequacy of the debate and upon the consequences which could flow from (an albeit admirable) sense of urgency with regard to the need to decide if all aspects of the whole question are not taken into consideration.

I would like here to repeat that it has been decided that "the well-being of unborn child must always be deemed the criterion to which reference must be made." We all agree that the well-being of the unborn child must be defended to the utmost. But why should we ignore the legitimacy of other requirements, such as late motherhood? Today great emphasis is placed upon the right of the unborn child to have two young and competent parents who raise him, and when this guarantee is not present the procedures of artificial procreation are not set in motion. This is a correct criterion which we can agree upon, but up to what point must it be seen as an absolute value? At what time in the past has this been considered an absolute right in all societies? In reality, the opposite is the case.

An attempt used to be made to ensure that children were born and at the same time less attention was paid to the fact of whether their natural parents were alive. This was because—and here we come to another aspect of the question—society was based upon extended families in which a mother was often absent (how many mothers died in childbirth?). Within the family there was often another woman (an aunt, a grandmother, etc.) who was prepared to raise an orphan. For this reason we should ask ourselves whether this strong stress upon the right of the unborn child—a right which is absolutely just—does not involve an overly favorable emphasis on the model and the idea of the nuclear and narrow family to the disadvantage of the extended family. And the extended family has been severely weakened not only by many serious social problems but in part also because of an inability to live with one another, because of individualism and because of selfishness.

All this illustrates the complexity of the debate about bioethics, the need to listen to the various needs and requirements which are involved, and the obligation we have to consider and identify answers and solutions which will serve the man who suffers. All this should be done without embracing facile expressions of permissive thought. Yet at the same time we should not fall foul of the temptation to reject everything out of a fear of what is new or because of attempts to guarantee social models whose legitimacy is by no means absolute even though they may well be very widespread. As the heirs to a tradition which we believe to be inspired, we are perhaps both advantaged and privileged—our path is in a certain way signposted and the choices we make are guided. This, however, does not diminish the responsibilities we must bear. On the contrary, it serves to increase them.

As Maimonedes wrote, medicine is "a special activity which is one of the most important known to man. It is a vital path which leads to the higher qualities and attributes of the human intellect, on the one hand, and to true awareness of the divine, on the other" (Chapter Five). The profound sense of the sacred which inspires this idea of medicine is a guarantee and a challenge for everybody, for a better kind of medicine at the service of man and at the service of the Creator.

Professor ELIO TOAFF
Chief Rabbi of the Jewish Community in Rome

AHMED ZRIBI

Medical Ethics and Islam

1. Definition of Islam

In chronological terms, Islam is the third monotheistic religion. It appeared after Judaism and Christianity to which creeds, indeed, it frequently refers.

The *Koran* ('Holy Book') forms the basis of Islam. This book was revealed to Mohammed by the Archangel Gabriel. The revelation of the Koran was begun in 610 AD and continued over a period of twenty years.

Islam is a complete system which governs both the spiritual and the civic aspects of the life of the individual and of the community. Islam embraces all fields of human activity: the spiritual and the material, the individual and the social, and the economic and the political.

2. Sources of the Charia

The *Charia* is a collection of Islamic laws which apply to all Muslims. The *Charia* draws upon, and is based upon, four sources:

1. The *"Holy Koran,"* or the true word of God, is a collection of dogmas made up of 114 chapters (*Sure*).

2. The *Sunna* is a collection of the words and deeds of the Prophet Mohammed which have been compiled by specialists of the *Hadith*.

3. The *Kyas*, or analogy, is a method by which it is possible to deduce a religious, moral, or juridical rule from another rule prescribed by one of the other two sources of Islam (the *Koran* or the *Sunna*).

4. The *Ijmaa* is the formulation of new rules by Muslim theologians or *Aimmas*.

The *Ijtihad* draws upon the last two sources of Islamic law (*Kyas* and *Ijmaa*). This is an intellectual attempt by the *Aimmas* to find answers to questions which are not dealt with by the Koran or by the *Sunna*. This gives a new evolutionary dimension to the precepts of Islam, a process which enables this religion to tackle each new question (such as those relating to medical ethics, to take one example) raised by the advance of science. In this paper which I will present here today an examination is presented of the various answers provided by the *Aimmas* to new questions of an ethical character.

3. The Bases of Muslim Morality

The *Charia*, or Islamic law, has three principles which each individual and the community must respect, and they are as follows:

– Bearing witness to the faith.
– Respect for human life.
– Reason.
– Filiation.
– Money.

Respect for human life means respect for the physical and mental integrity of man. This is borne out by a reading of a number of verses from the Koran:

"In truth, we created man in harmonious forms," Sura 95, (verse 4).

"Do not alter the creation of God," Sura 30, (verse 30).

"God breathed His Spirit upon man," Sura 32, (verse 9).

"We conceded nobility to the children of Adam," Sura 17, (verse 70).

Respect for filiation means the defense of genealogical continuity and of filiation itself.

In a Hadith Mohammad said: "Have a knowledge of your genealogies which enables you to be careful about ties of blood kinship."

The Koran says:

"God forbids adopted children being considered as real children," Sura 33, (verse 4).

"Adopted children should bear the name of their father," Sura 33 (verse 5).

Thus it is that respect for life, for filiation, and for reason are the three fundamental elements at the base of Islamic medical ethics.

4. The Nature of Islam: The Spirit of Tolerance and Liberalism

The idea of tolerance is to be found in a broad range of verses of the Koran:

"God wants happiness for man and not suffering," Sura 2 (verse 185).

"God does not burden men with weights they cannot bear," Sura 6 (verse 152).

"God does not ask from men more than they are capable of doing," Sura 7 (verse 42).

"Let there be no compulsion in faith because the upright path naturally distinguishes itself from the path of 'error.'" Sura 2 (verse 256).

In Islam both obligations and prohibitions are relativized. The Koran declares:

"He forbids you to eat the flesh of dead animals, the blood and the flesh of the pig and of butchered animals, but he who is forced to eat these forbidden things will not be seen by Us as a rebel or a transgressor. In truth, God is Merciful and Compassionate," Sura 16 (verse 116).

After outlining some of the characteristics of Islam, and in particular the basic elements of its morality and its spirit, we will now consider,

firstly, the ethics of Hippocrates—ethics which to a great extent are to be found in Muslim morality—and secondly the approach of Islam to those new ethical problems which have been raised by the development of biology and of treatment over the last three decades.

5. Hippocratic Ethics [7]

The term "ethics" is often confused with "morality." At the present time the term "moral" refers to the actual behavior of an individual or a community whilst the term "ethics" refers more to a reflection upon this behavior. Both vary from one society to another and from one space to another.[5]

Notwithstanding this variability, the four ethical principles of medicine accepted by all doctors over the last twenty-five centuries (Hippocrates) are independence, benefit, the intention not to do harm, and justice.

Independence includes respect for the individual and the freedom of the individual. Benefit involves the doing of good to others. The intention not to do harm refers to the duty to not do wrong to other people.

Justice in medical ethics relates to the provision of care and treatment to patients without discrimination in relation to matters of race, religion, wealth or social condition, and so forth.

1. The Principle of Independence

Every person feels free and independent. He is controlled and governed by God the Creator alone. Islam has attributed great value to reflection and learning.

The first verse revealed by God to Mohammad says: *"Read in the name of your God who created man,"* Sura 96 (verse 1). In addition, many Hadits or words of the Prophet lay great stress upon respect for the individual, upon reflection and upon thought:

"No prayer is of the same worth as reflection and contemplation."

"Woe to those who read and do not understand."

"An hour of reflection is better than a night of prayer."

Furthermore, we have seen that reason is one of the fundamental elements of Islam. Islam has placed great emphasis on freedom in questions of religious belief as well. Thus it is that the principle of independence is clearly to be found in Muslim morality.

2. Benefit

The Koran encourages charity and decrees it both for individuals and for the community. The giving of alms, or *Zakat*, is one of the dogmas of the Muslim religion. The Koran promises a reward for each person who does good. The *Hadit*, too, encourages charity:

"The Muslim who promotes an action or cultivation of the soil which provides sustenance for a human being, an animal or a bird, will be rewarded in the world beyond."

"A person can avoid punishment in the world beyond for bad actions by planting a palm."

3. The Intention of Not Doing Harm

The principle of not doing harm is mentioned by the Koran and by the *Hadith*. The *Hadith* says:

"Do not have difficult relationships. Do not be jealous of each other and be brothers in prayer."

"Each person must respect the feelings of his neighbors and not be brusque in his actions, words or the movement of his hands."

4. Justice

We find the principle of justice in a number of verses of the Koran and in various *Hadiths*.

The Koran says:

"Those who persecute believers without good cause commit a manifest sin and a most wrongful act," Sura 33 (verse 58).

"Nobody should come to the help of embezzlers," Sura 22 (verse 7).

"If two groups of believers come to fight, make peace between them. If one group rebels against the other, fight that which rebels until they submit themselves to the order of God. If this group obeys, then make peace between them with justice," Sura 49 (verse 9).

Thus do we find the principles of benefit, of not doing harm, and of justice in Muslim morality. These principles are to be found in the various oaths of the physicians who have practiced in the land of Islam. At the beginning of the Muslim era the Muslim sages were highly influenced by Greek civilization in the development of their own form of civilization. Some of the ethical texts of the land of Islam may now be cited.

a) *The Oath of Mamonide Moses (1135-1204 BC)*

Moses was of Jewish culture and was the private doctor of Saladin the Great. His oath placed great emphasis upon the principles of benefit and of not doing harm.

b) *The Oath of the Muslim Doctor (1981)*

This oath was adopted at the first international conference of Muslim medicine which took place in Kuwait and whose acts were then published by the Organization of Muslim Medicine in 1982. This oath lays down that the doctor must respect the dignity and the intimacy of the patient and must not divulge secrets about that patient. The oath also stresses the principles of benefit, not doing ham, and justice.

Thus one can see that Hippocratic ethics have been adopted not only by medical doctors in the land of Islam but also by physicians drawn from other religious cultures, and in particular those of Judaism and Christianity.

However, over the last two or three decades the dual revolutions in the spheres of biology and medical treatment have raised new and weighty problems of an ethical character. How have doctors approached these problems and what solutions have they found?

As we have already seen, the two fundamental principles of the *Charia* (Koran and *Sunna*) are unalterable. The *Kyas* and the *Ijmaa*, on the other hand, provide for ethical reflection upon the circumstances and the solutions to problems which are not dealt with in the Koran or the *Sunna*.

6. Islam and the New Problems of Medical Ethics

Over the last twenty years the new problems of an ethical character which have been raised by advances in biology and medical treatment have given rise to a large number of Muslim seminars and conferences. These conferences have called upon health care workers, men of religion, and men of law to find answers to these problems, answers which are in line with the Muslim *Charia*.

1. Family Planning

Islam certainly encourages procreation but it also allows family planning under certain conditions.

1.1. Contraceptive Methods

The technique of coitus interruptus to avoid pregnancy is not forbidden by Islam. Although this matter is not dwelt upon by the Koran, certain words of the Prophet (*Hadith*) authorize this method.

The *Kyas*, or analogy, has allowed the *Ammas* to authorize contraceptive methods on the condition that they do not damage the health of women; these methods are the rubber sheath, the diaphragm, the pill, and so forth.[2]

1.2. Artificial Procreation

Islam has insisted greatly on respect for, and the defense of, genealogical continuity and filiation.[2-4]

The Koran says:

"God forbids adopted children being considered as real children," Sura 33 (verse 4).

"Adopted children should bear the name of their father," Sura 33 (verse 5).

A *Hadith* of the Prophet says, "Have a knowledge of your genealogies which enables you to be careful about ties of blood kinship."

In this way the Koran and the *Sunna* emphasize the need to ensure that genealogical continuity eliminates the risk of incest and acts to defend the patrimony of a family.

1.2.1. Artificial Insemination

This technique involves the direct placing of sperm in the uterine cavity when there is a case of conjugal sterility. It is tolerated by Islam as long as the sperm which is used is that of the legal husband.[2 4]

1.2.2. In Vitro Fertilization and Embryo Transfer

Here in vitro fertilization is involved. An ovule and spermatozoa are gathered and placed together in a test-tube. The ovule is thus fertilized by the spermatozoa.

After forty-eight hours this beginning of the embryo is placed in the uterine cavity. This in vitro fertilization is tolerated by Islam as long as the ovule which is fertilized comes from the union of the ovule of a wife and the spermatozoa of the husband. We can thus see that the giving of sperm is allowed by Islam.[2-4]

1.2.3. Hired Motherhood

If a woman cannot bring a pregnancy to a happy conclusion, but has ovaries, one or more ovules can be taken from her and then fertilized in vitro with the sperm of the husband. After forty-eight hours the embryo thus obtained in placed in the uterus of another woman who returns it after nine months. This practice is forbidden by Islam.[2-4]

1.3. Sterilization

– Temporary sterilization as a contraceptive device is tolerated by Islam.[2-4]

– Irreversible sterilization is forbidden by Islam unless it is aimed at defending the health of the person who is to be sterilized. [2-4]

1.4. The Voluntary Interruption of Pregnancy

We have seen that Islam commands respect for the physical integrity of the individual.

On the other hand, Islam believes that the embryo is a human person from the one hundred and twentieth day of being in the womb.

The Koran says: "We transformed the sperm into a clot of blood, and the clot of blood into a piece of shapeless flesh, to which we gave bones with which it was dressed: this is a new creation. Give praise, therefore, to God the All-Powerful," Sura 23 (verse 14). Mohammed said (*Hadith*): *"The creation of a person in the womb of the mother goes through the following stages: forty days in the form of earth, forty days in the form of an adhesion, another forty days in the form of a piece of flesh, and then God sends an archangel who places the spirit within it."*

This explains the stance of Islam in relation to the voluntary interruption of a pregnancy. The views of the *Aimmas* on this point vary and at times move between tolerance for abortion before the first one hundred and twenty days of pregnancy, tolerance when there is good reason, and total prohibition of the practice.

The present-day position of Muslim morality in relation to the voluntary interruption of pregnancy has been summarized by Jel El Hakm, the Mufti of Egypt:[2]

– The voluntary interruption of pregnancy is tolerated before the hundred and twentieth day if there is a valid reason—that is, if the life of the mother is endangered or if the embryo has serious genetic defects which would prevent its survival after birth or which would be transmitted to subsequent generations.

– After one hundred and twenty days of pregnancy the voluntary interruption of pregnancy is prohibited except if the life of the mother is in danger.

2. The Contemporary Development of Genetics and Islam

Three principles of Muslim morality enable us to find a solution to this question: respect for the integrity of the human person, benefit, and not doing harm.

2.1. Genetic Exploration and a Genetic Identity Card

The genome defines a species and an individual. This is a specific print which enables an individual to be recognized. F. Ben Hamida has said[4]:

– Islam must approve the use of genetic prints to establish the rights of filiation.

– Islam must also approve the use of genetic prints as evidence or proof of the guilt or innocence of an individual (justice).

2.2. Prenatal Diagnosis

The prenatal diagnosis of certain congenital malformations or inherited illnesses involves the question of the voluntary interruption of pregnancy (see above).

2.3. Genetic Manipulation—Genetic Therapy (4)

Genetic manipulation involves the modification of a gene or the introduction of a gene which affects an organ or the whole organism. The modification of an organ through the genetic gene is tolerated by Islam if the aim involved is that of curing an illness.

The modification of a whole organism is officially forbidden by Islam because such an action amounts to the modification of a divine creature.

3. The Transplant of Organs

The transplanting of organs has undergone a notable development over the last three decades.

In 1990 the Second Congress of the Society for the Transplant of Organs of the Middle East was held in Kuwait.[4] This congress encouraged the practice of the transplanting of organs and deemed it a good action (*Hasana*) and an act of almsgiving (*Sadaka*).

It should also be observed that the Council of Arab-Muslim Ministers has adopted a program on the transplant of organs.

The Tunisian law of March 25, 1991 on organ transplants is close in character to the Kuwait proposals.[6]

3.1. The transplanting of organs is tolerated by Islam except when the reproductive organs are involved—and this out of respect for genetic continuity—or when the vital organs are the objects of transplant.

3.2. Live Donors

The transplanting of organs is possible as long as the donor is an adult and has the full use of his mental faculties and enjoys full legal status; he must also have freely and expressly consented to the donation of his organs.

3.3. Dead Donors

Organ donation can be effected for scientific or therapeutic reasons from the body of a person as long as that person, when he or she was alive, did not make known his opposition to such an action, or as long as the following figures (assuming they bear full legal status) do not express their opposition, and in the following order of importance: children, father, mother, spouse, brothers and sisters, legal guardian.

The removal of organs for the purpose of a transplant from the corpse of a minor or a person of diminished responsibility cannot take place unless there is the prior consent of the legal guardian.

4. Therapeutic Obstinacy and Euthanasia

As we have seen, the defense of life is one of the fundamental principles of the Muslim religion.

In Islam nobody is authorized to put an end to his days or to the days of another person, even if that person is afflicted by an incurable illness. Islam, therefore, prohibits euthanasia even if the sick person asks for it.

5. Medical Research

The first five verses of the Koran, with their praise for the pen as an instrument of human science—that is to say of the civilization and the culture of man—constitute the very first revelation made to the Prophet Mohammed. *Sura* 96 (verses 1 to 5).

This bears witness to the importance attributed to knowledge and research by Islam.

The first international congress on ethical rules for research in the field of family planning in the Muslim world, which was held in Cairo, December 10-13, 1991, laid down the following rules.

1. Medical research on man constitutes a part of research in general.
2. Ethical rules for medical research must be established.
3. The ethics of medical research must be based upon the following principles:

a) such research must be for the benefit of man;

b) it must not harm man or society;

c) it must conform to justice in the sense that research must not be carried out on one group (or class) to the advantage of another group (or class);

d) it must involve total trust, both as regards the creation of a project of research and its implementation and the communication of the results of that research project and their publication.

Conclusion

The medical ethics of Islam are based upon the fundamental elements of the Islamic religion (the *Koran*, the *Sunna*, the *Kyas*, and the *Ijmaa*) and express the ethical principles accepted and promoted by most of the medical doctors of the world from the age of Hippocrates to our days.

At the same time we have seen that because of the tolerance and the liberal spirit of Islam and the commitment to reflection and thought (*Ijtihad*) of the *Aimmas*, the medical ethics of Islam have been easily adapted to the new problems raised by the dual biological and therapeutic revolution which we have experienced over the last thirty years.

Professor AHMED ZRIBI
Director of the Department of Internal Medicine and Infectious Diseases at the Rabta Hospital in Tunis, Tunisia

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* Translator's note: the translations from the Islamic texts are taken from the Italian version of the paper delivered to the Conference.

ALESSANDRO BERETTA ANGUISSOLA

Language and the Dissemination of Medicine

Communication is a technique which has to be learned. The question of language and the structure of scientific information is very complicated and varies greatly according to the goals which are aimed at, and in particular in relation to the object-dimension of the communication.

This learning should be a part of the process of training the scientific researcher and thus of the medical doctor as well, who, after all, is first and foremost a biologist (even if he is not only a biologist but something rather different). University teaching, on the other hand, as it is presently understood within the medical training programs, is fundamentally based upon criteria which are now obsolete. It is the expression of an outlook which was imposed by the prestigious German schools almost everywhere during the course of the second part of the nineteenth century. This model was certainly based upon great methodological rigor but it does not supply a sufficient response to the needs and requirements of a form of society which has changed radically, and, of course, only natural. One of the special aspects of the new needs and requirements of today's world is the demand for information in the sphere of science and technology, and particularly in the field of biology and medicine.

The insertion of new scientific facts into the tissue of codified knowledge is no longer adequate. The very "newness" of what is learnt means that this new knowledge must be disseminated widely, especially when it destabilizes the previous conceptual framework and thus has a major impact upon existing ways of thinking and acting. This is particularly true in relation to the world of medical research.

It has been said that the medical doctor is not only a biologist. It is man, and in particular sick man, who forms the subject of his studies. The relationship with the subject of his research is thus very complicated and intricate. It does merely involve knowledge, it also touches upon ethics; it is not merely scientific, but it is, taken as a whole, human (or humanistic to use the term commonly in use in Anglo-Saxon countries). Indeed, it draws upon the values of existence not only of the body but also of the spirit, not only of the individual but also of society as a whole. For this reason medical information has an especial impact and resonance. It has, that is, a very high "audience share." But medical communication, precisely because of its inner complexity (its scientific, ethical, legal, ethical and social implications and consequences), is especially difficult to absorb at a technological and technical level. For this reason, it would be a good idea to make it the subject of correct and rigorous study in university training programs.

For the sake of clarity I would like to divide—albeit in rather arbitrary fashion—the dissemination of medical information into three categories: that which touches upon the individual sick person, that which concerns the family, and that which involves the community more generally. In all three contexts the fundamental problem always relates to the question of language. How would it be possible to inform people without a language which was suitable and particularly open and comprehensible? But in contrary fashion each profession—and perhaps the medical profession does this more than any other—uses its own technical and highly specific language which can only be understood by members of that profession. Speaking and writing in a way which is clear and simple is never easy and this is especially true when we come to consider medicine.

The acquisition of this ability is of the essence for the medical doctor, and this is especially true when we consider today's world. Nowadays the sick person and his family environment are not without a certain amount of biological or medical knowledge. We have to recognize that the modern means of mass communication have brought a number of ideas and notions out of the ivory towers of the various academic disciplines and spread them far and wide. We are faced with a widespread cultural context which is certainly elementary, disordered and incomplete but which is nonetheless of a sufficient standard to pose questions, ask for clarification, and even at times raise objections which are by no means groundless. We have, therefore, to ensure that the medical doctor speaks and explains things (of course, in a natural and prudent fashion) and uses a language which is both clear and effective. The patient has the right to be informed about the nature of his illness, about the procedures and the results of the tests to which he is subjected, and about the treatment which he is to receive—treatment which is at times intensive and intrusive. This is necessary to ensure that the patient consents to the action and proposals of the doctor in tacit if not explicit fashion, and there can be no real consent unless such consent is based on correct and suitable information.

At a practical level we have to recognize that such information when supplied by the doctor is very often inadequate both as regards the language used and in relation to the content of the message. It often happens that in the wards and corridors of hospitals and clinics the communication between doctor and patient which should take place does not take place. There are, instead, hurried and vague expressions or incomprehensible technical sentences. In addition, information is imparted especially by young doctors which is unwise, disturbing, and premature. With family relatives as well,

information is often sparse or non-existent. Perhaps a few moments, standing up, and communicated in public. It is almost as if by the very fact of being a patient in a ward (where perhaps he has been placed because of the availability of bed-space and where he does not know anything about the health care workers or the environment more generally) the doctor who is to treat him has a kind of *carte blanche* in relation to his case. It is almost as if the doctor is not obliged to give the patient information about his condition or treatment and particularly is not required to obtain his informed consent to the decisions which will be taken on to how to treat his condition. But the communication of information is not only a necessity. If well managed in relation to its language and its content it can be a subtle art of extraordinary effectiveness in the humanization of the relationship between the patient and the doctor. It can also be of very great help in the actual treatment of the patient.

The spread of medical ideas and concepts within the community at large is quite another matter. It has already been observed that there is a high level of audience share for medical information and news on television, on the radio and in the press. Indeed, we here touch upon one of the forms of popularization of information which has the greatest success in today's world. The popularization of information does not of itself mean inferior, rough or superficial communication. It merely means—as Escarpit observes—the putting into circulation of scientific and technical information for the benefit of non-experts. If this is effected with clear and comprehensible language which is free of technical terms but scientifically rigorous in character (that is, absolutely exact in what it communicates), then the popularization of medical knowledge which is prudent and discreet, and lacking in any element of advertisement or of self-advancement, is clearly a vital and necessary feature of the health education of the population. Indeed, for these reasons it should be further developed and, above all, better directed.

The television in particular could really "educate" if it were oriented not only towards providing information on debates and interviews about human illnesses and their treatment but also towards directly "informing" the public about the great questions of prevention (an endless and essential area of information)—questions which are of

vital importance to everybody at all stages of life. It is certainly true that today's society behaves in an irrational way in relation to health, yet documented and objective information about prevention, if presented with correct and effective language, could in the long run obtain great results and help to change forms of behavior which are damaging to health. One need only think here of the very great successes which have been achieved in the campaigns against smoking in the Anglo-Saxon countries through health education. Or of the very close relationship between man and his environment and of how useful it would be to provide widely disseminated information in this very important area. But the dissemination of information amongst non-experts is difficult and—as has already been observed—either one has it in one's blood or one does not, and this is also true of scientists and researchers. It is very easy to fall into even major errors out of an excess of enthusiasm or because of the wrong use of language. For example, one of the most common errors is to be found in the so-called use of metaphorical language. The use of metaphors drawn from the environment which surrounds man, for example the comparison of the human organism with a machine, however complicated they may be, is a method of popularization which is very mistaken. Man is not a machine, he is *homo sapiens*. The medical doctor is not a mechanic who mends broken parts: he is a conscience in whose hands trust is placed.

A popularization of information in relation to medicine which does not always present the humanistic side to realities gives credence to the worry that modern medicine is becoming poorer in human terms in a way which is correlated to the pace of its technological advance. As its analytical knowledge of the mechanisms of disease grows ever greater, medical science runs the risk of losing sight of its real concern, the sick man. If in addition it does not manage to stop what has been termed the "hemorrhage of the soul," it further runs the risk of failing in its goals at precisely the moment when it has reached the high point of its scientific knowledge. This is why the correct dissemination of information can perform a function in today's world which is of incomparable value.

Professor ALESSANDRO BERETTA ANGUISSOLA
President of the Italian Institute of Social Medicine

MASSIMO BALDINI

The Doctor-Patient Relationship in Medical Textbooks and Manuals of the Eighteenth and Nineteenth Centuries

> *"The choice of the doctor must be based upon his good moral and personal qualities, or upon his knowledge and skill. This means upon bases which inspire trust and confidence because without such elements the sick man will adopt a wrong or misguided attitude towards himself or towards the doctor."*
> –Salvadore Mandruzzato

1. "Small Medicine" and "Big Medicine"

In the twentieth century science and the work of scientists have undergone great changes. Indeed, during this century we have passed (to use an expression favored by De Solla Arice)[1] from "small science"—science characterized by isolated researchers financed by a patron or out of their own pockets and engaged in experiments and observations, science that is to say as it was at the time of Galileo and at the beginning of this century—to "big science", that is to say the science of a research team, a form of science which requires large and substantial economic backing.

In "big science" the figure of the *amateur* scientist or researcher disappears. This was a figure who for the whole of the eighteenth century and for a large part of the nineteenth century made substantial contributions to the advance of scientific knowledge. "Big science", on the other hand, like much other activity of the end of the second millennium is crowded and rapid in pace. The man of science of today's world lives in a situation which has become strongly competitive. The advice which Ehrlich gave to his pupils ("work hard, publish little") is no longer followed by people active in the world of research.[2]

"Big science" is the science of specialists and specialties, the science of those scientists who deal with very sophisticated knowledge in ever narrower spheres of reality. "Big science," as distinct from "little science," is strictly linked to the world of production. In other words, as industry became more scientific, science itself became more industrial in character and orientation.

During the nineteenth century there was a passage from "little science" to "big science" and at the same time in parallel fashion there was a transition from "little medicine" (that of such figures as Redi or Murri) to "big medicine." The medicine we have before us now has certain key features which ensure that it is radically different from medicine as it was practiced until the first decades of the twentieth century.

In particular the practice of medicine has been marked by a massive technological change operating at a general level. The positive consequences of this transformation are obvious to all, although it must be pointed out that the negative aspects are not always readily appreciated. There is a risk, for example, that the medical doctor will end up by becoming the appendix of a technological instrument and will engage in a kind of theoretical passivity. In other words, there is the risk that technological progress will cause a progressive decline of real medical action within the medical class.

Furthermore, "big medicine"—like "big science"—has been very much marked during the twentieth century by the birth of specialization. During the nineteenth century the phenomenon of specialization within the world of doctors began to emerge; during our century it has become widely rooted. The phenomenon of specialization is at the same time both a negative and a positive phenomenon. It does indeed allow our scientific knowledge to advance but at the same time it undermines the organic character of science and leads us to lose sight of overall patterns and realities.

Thirdly, "big medicine" is not only a kind of medicine which tends to a loss of the relationship with the patient as a psychophysical unit because of the above mentioned specialties, but it also involves a bureaucratization of relationships with the patient. The medical doctor, that is to say, tends to forget that the most important medicine is he himself and he increasingly becomes a "cold blooded vertebrate", a sort of gray and tired bureaucrat.

The move from "little medicine" to "big medicine" has had major consequences for the role played by the medical doctor within society, for his prestige, and also for his deontological and ethical duties and obligations. If knowledge is power, as Francis Bacon said, then it is obvious that the more medical knowledge expands the more complicated become those ethical and deontological problems which the practitioners of the art of medicine are called upon to deal with in the exercise of their profession. This is so real a phenomenon that at the beginning of the 1980s Stephen Toulmain, a famous epistomologist of the English language, was lead to observe that the biomedical sciences had brought ethics back to life. In his opinion, indeed, thought in the ethical field had been in a state, so to speak, of suspended ani-

mation for a number of decades and had been progressively marginalized within cultural debate. Advances in certain branches of scientific knowledge, and above all in biomedical disciplines, acted to draw experts in ethics out of the ghetto in which they had been previously placed.

2. Textbooks and Manuals for Doctors and for Patients

In the works of many physicians from the days of Hippocrates to contemporary times, we usually find reflections and ideas of a deontological character. However greater emphasis has been given to such matters when the role of the doctor has experienced moments of crisis, and at the beginning of the nineteenth century this emphasis became very marked indeed. In the years following the French Revolution a complicated and difficult process began which sought to redefine the professional figure of the doctor, his knowledge, and his role within society.[3]

For the whole of the nineteenth century in Italy and in other European countries there was a flow of tracts, academic monographs, catechisms, and textbooks, not to speak of dissertations aimed at defining the qualities of the ideal doctor. These writings were couched in different tones.

They were polemical, apologetic/propagandistic, or moralistic) and from their pages emerges, in the words of Maria Luisa Betri, "the image of a medical class which was disorientated, weakened and lacerated by internal conflict, almost besieged by the medusa head of charlatanry, the subject of acrid popular satire or the skepticism of the educated classes. At the same time, however, this medical class was aware of the need to achieve new doctrinal cohesion, to adapt practice to unifying principles, to uphold and defend the dignity of the profession, and to defeat illegal practice."[4]

These were works directed first and foremost at young doctors who were taking their first steps in their profession but at times they were also directed towards "every class of educated person."[5] And in those works addressed to doctors one can also read the secret hope (between the lines) that the pages would be read by non-specialists. Giuseppe De Filippi wrote: "I hope that this textbook will also fall into the hands of people outside the art of healing, and that it deserves to be seen by everybody who is connected with physicians. I would venture to say that if the medical doctor can find useful advice in this book, then society may be able to find a splendid truth which will illuminate it in relation to the role and character of medical doctors and medicine."[6]

The causes of the proliferation of writings of this kind and character are manifold and emerge more clearly if we take an overall view of

the various goals of these textbooks—goals which are not usually considered in isolation but are analyzed within a more general hierarchy.

a) The Apologetic/Propagandistic Function of these Works

Between the end of the eighteenth century and the first decades of the nineteenth century, the figure of the doctor was surrounded by diffidence and suspicion, hostility and rejection. In order to create new trust in the abilities of the medical class, in order to obtain legitimation by the state and by patients, a number of textbooks and catechisms were published in addition to tracts and introductory lessons to university courses, and all of these publications were full of praise and admiration for the work of medical doctors. These works had the function of being apologias or propaganda and they sought to restore the credibility of doctors by praising their merits and sacrifices and seeking "to inform civil society about how doctors should be seen"[7].

"Who is a medical doctor?" asked Giuseppe De Filippi in rhetorical fashion. He is a man, he answered, who "spends his time in the most severe processes of learning; is subject to all kinds of privations; spends his nights awake; spends time in hospitals and with corpses engaged in activity which is more tiring than any other form of human activity. Trained in the practical exercise of his profession, he embraced the mission of offering himself at all times as a voluntary victim for the public good. It is the medical class that can really boast the qualities of heroism and cold courage, something which all the warriors in the history of the nations could not put into the field."[8]

b) The Development of the Conscience of the Medical Class

Given that doctors were for the most part surrounded by a general lack of admiration and prestige, and given that a great many unflattering things were said about them, these works sought to disperse the demoralization which pervaded the practitioners of the art of Aesculapius by emphasizing their social importance and instilling a more deeply rooted awareness of their own professional status.

During the first part of the nineteenth century medicine found itself in a deep crisis of capacity—the successes in the field of bacteriology were yet to take place. However, and even though methods of treatment were still largely ineffective, medical knowledge was acquiring revolutionary new techniques by which to examine the sick body: "the percussion invented by Avenbrugger, the stethoscope invented by Laennec, and the pleximeter invented by Piorry."[9] Upon the basis of such minor scientific steps forward, and fired by faith in the advance of scientific knowledge, the various writers described above sought to give new coherence to the medical class, a professional category which at that time was largely distrusted and largely divided into conflicting and factious schools.

In this sociocultural context the following statements contained in a famous and successful work by

Roberto Sava (*On the Qualities and Duties of the Physician*) had the function of calling upon doctors to unite in the defense of the value and the importance of their art: "Because of the dignity of his profession the doctor finds himself in the front ranks of society."[10] And he continued: "The doctor knows no profession which is more noble than his and there is no position higher than his. The most powerful sovereigns give up their days to him and blindly obey his orders. A great medical doctor is the first of men: by means of the advances he makes to improve the art of healing, the physician becomes the benefactor of mankind. And because of his rule in relation to death he is to a certain extent the image of the divine on earth. In the exercise of the functions of the doctor are to be found all the virtues. His ministry commands the respect of men and attracts the admiration of the wise."[11]

c) The Function of Being a Polemic against Charlatans and Medical Charlatanry

At the beginning of the nineteenth century all the authors of the above mentioned works implicitly attacked, or more frequently explicitly attacked, the charlatans. With "great courage and marked constancy," the doctors were called upon to fight "money-makers," "deceivers," "quacks," and "frauds." In this battle against impostors in the realm of medicine, the sons of Aesculapius also formed a front against "medical charlatanry." That is to say against those attitudes and practices of their professional colleagues which were too near the activities of the charlatans.

Sava observed that there were many similarities between charlatans and insects: "like insects charlatans are everywhere to be found acting in partnership; they often change their shape and form and take on a thousand guises. Some seem to have wings like butterflies and these are the qualified charlatans who have reached very high positions. Others are like bedbugs which are recognized by their bad smell and always have foul smelling breath. Others live out their sad existence and like mites seem to be almost invisible. Others shine forth in full day, inhabit great drawing rooms, and the noise and the din that they make manages to attract the attention of observers and the curious—they are like great beetles noted for their size and strange shape."[13]

d) The Function of Being Polemics Against the Detractors of the Profession

The doctors felt themselves besieged by their detractors. They were the butt of the sarcastic comments of "philosophers and poets" but they were also criticized by the sick and their relatives who often

accused them of "slanderous crimes." Many academic discourses, like that given by Emmanuele Basevi in 1826, sought in very real terms to demonstrate that the science of medicine really existed and to make clear that doctors were both useful and necessary[14]. Against the detractors and against all those who were ready to chastise the doctor "with wrongful accusations, with prejudices and errors of all kinds, with incompetent and erroneous judgments, with derision for his learning and with vilification of the art that he professes,"[15] an initiative was taken of a public relations character, something which was unique in the history of medicine.

Many authors and authorities stressed the long periods of study which doctors had had to engage in ("a doctor who loves learning has languished for fifteen years in the schools and the colleges of anatomy and the study of the human body")[16]; drew attention the very bad conditions of the doctor's life (he spent the best years of his life "in the infected air of hospitals")[17]; emphasized his efforts and his initiatives; and concluded by observing that "civil society" had to be fair and recognize the value of the art of medicine, and thus allow the doctor to sit "in the human hall at that place which the importance and the nobility of the profession has raised him."[18]

e) The Deontological Function of these Writings

Between the eighteenth and nineteenth centuries medical studies underwent a profound transformation. First of all, the medical profession had acquired those "practical and theoretical features which made the figure of the medical philosopher obsolete, a figure separate from and in opposition to the surgeon or the phlebotomist. In the new state of affairs actual ability at the bed of the patient, which had previously been delegated to a hierarchy of subordinates, now acquired a new character and a new importance."[19] Secondly, members of the middle class or the lower middle class began to enroll in the medical faculties of the universities. These classes had previously supplied most of the recruits for the professional bureaucracy much needed by the emergent liberal state.

The medical faculties, therefore, became ever more crowded for the times ("the medical studies are almost besieged by people" wrote Ranzi)[20] and the obvious result of this was that there was a lowering of standards in relation to medical training and formation. The art of Aesculapius thus became filled with new men who did not have a medical doctor or a chemist as a member of their family, and because they did not have a family tradition behind them they required a very careful training in relation to ethics and professional codes of practice.

Many works of experienced doctors were directed towards making clear the character of the professional code of conduct of the profession or even the basic rules of good behavior to which doctors should adhere. The medical manuals and textbooks took a clear position against the decadence of a pro-

fession which had become a "a very low trade,"[21] against the "hungry vampires" and "newly emerged little know-it-alls,"[22] the adventurers with a thirst for gold. the "idle and ignorant physicians," the "wild practitioners," the "business doctors" and the "deceivers of the sick."[23] They also listed the basic characteristics of what they considered the ideal doctor. This was a by no means easy task, not least because it involved attacking professional vices which had become strongly rooted over time and which had become even worse because of the increase in the number of people practicing the craft. However, it was an important battle because, as A. Dechambre pointed out: "the dignity of the art of medicine and the duties of the doctor are closely connected."[24]

e) The Methodological Function of These Textbooks and Manuals

The authors of these medical textbooks and manuals and the various tracts on professional conduct sought to give elementary advice in matters relating to method to doctors, nearly all of whom lived in "poverty or humble mediocrity."[25] Doctors also had to compete for patients with ignorant charlatans who were nonetheless cunning and energetic, and perhaps because of the precarious economic condition of their families had taken "exams which were never severe."[26]

This advice was concerned with how to put questions to the patient, how to study their case histories, and how to prescribe medicines and drugs. These works emphasized that it was very important not to fall into a sort of "plying of a trade" that is, a mere "mechanistic practice" of the medical profession, as usually happened in the hospitals of the time. In order to avoid becoming "doctors of routine," victims of sluggishness of the spirit, great stress was placed upon the need to keep up with medical developments and progress. Medical doctors were also invited to be careful about adopting systems ("at the bed of the patient preconceived ideas should not be operative; eyes must be kept from being blurred by systems," in the words of De Filippi).[27] They were also reminded that "the doctor determines practice just as practice makes the doctor."[28]

g) The Function of Educating and Training Patients

During the nineteenth century an increasing number of people turned to doctors in repeated fashion. Ever larger section of the population—at first the middle class, then the lower classes, and much later, outside the towns and the cities, the workers of the countryside—knocked at the doors of the medical profession. Furthermore, and here indeed there was a break with the past, patients who were not in very difficult con-

ditions of health were taken to doctors for consultation.

Many enlightened doctors thus began to write manuals and textbooks expressly for patients in order to achieve their cooperation and their consent to the project of directing the sick towards the "helpful medical doctor" and not towards the "actual impostor." In reality, many of these publications also contain a message of the "I tell you daughter-in-law because I am your mother-in-law" kind.

Indeed, although these works are addressed to patients they also acted to criticize doctors and thereby correct their worst characteristics. The authors of these publications believed that if people were sufficiently educated they would escape the clutches of the quacks and adventurers, they would be critical in their approach, they would cooperate with doctors in describing their symptoms and case histories, and they would help to produce a social consensus necessary to the success of the medical profession.

3. The Relationship Between the Medical Doctor and the Patient

In the textbooks and manuals for doctors and patients rules were outlined aimed at creating a correct and effective relationship between the doctor and his patient. The doctors, it was argued, should be "charitable, prudent, secret and modest."[29] They had to treat "the sick with sagacity."[30] The doctor, Macappe goes on to say, should not be "too severe or easy with the patient because excessive severity provokes the hostility of the patient and excessive easiness generates mistrust."[31] The doctor must have "an attitude made up of courtesy, seriousness, and readiness to help"[32] if he wants to gain the trust, the esteem,and the respect of the sick people he deals with.

Patients, for their part, were invited to avoid being gullible or loving marvels because such an approach would lead them to prefer "charlatans and charlatanry wherever they may be found."[33] Furthermore, the ideal patient should "employ diligence in the use of medical prescriptions"[34] and should never try to "deceive the doctor with false descriptions of the use and consequences of the medicines prescribed to him." (35) Indeed, "whoever deceives a medical doctor offends himself and his neighbor."

All the authors of these manuals and textbooks lay especial stress upon problems connected with communication between the doctor and his patient. Coletti writes that the doctor should "let speak rather than speak himself; listen to what is not relevant and only say what is really necessary"[36]. In another aphorism he declares: "the doctor should enter the room of the sick person in a careful and not hurried fashion; he should speak rather than declaim, ask questions and not suggest."[37]

The eloquence of the doctor, Del Chiappa asserts, must be "ingenuous, upright, and noble"[38] but also, and first and foremost it must be "clear and limpid."[39] The medical doctor, that is to say, must "explain and reason with such clarity and simplicity that the force of what he

says is fully perceived. Everybody should be able to understand the meaning of what he says, and everybody should be convinced and struck by the rightness of what he says. He should not in the least employ that technical vocabulary infected by inappropriate Greek terms or softened by vulgar phrases."[40]

In truth, one of the causes of the diffidence with which doctors were held by patients was to be attributed to the obscurity of the language they used, their "empty logomachy."[41] It was difficult for patients, and even educated patients, to find major differences between the language used by real doctors and the language used by charlatans—both forms of language were rather impenetrable.

If doctors wanted to distinguish themselves from the charlatans they had to find a language which was effective and translate their concepts into a form which was not alien to their patients. In other words, they had to engage in different linguistic practices to those of their predecessors.

In his cynical aphorisms of a political/character, Alessandro Knips Macoppe had already railed during the eighteenth century against those "doctors who employ pompous expressions, declare themselves all-knowing, and use a language which cannot be understood by ordinary people"[42] and had advised his colleagues not "to tolerate ways of expressing oneself which can be found in the mouths of charlatans and impostors.

He who uses such language seeks to deceive the sick and not to cure them."[43] However a few lines previously he had expressed the view that the doctor should "always be ambiguous in formulating judgments about the future course of the illness,"[44] that is to say that he should get over the problem by "formulating vague previsions in the style of the prophecies of the ancient sibyls."[45]

This ambivalent approach which oscillated between a real wish to promote clarity and the need for a lack of disclosure was slowly abandoned in the first decades of the nineteenth century. The good doctor, it was observed at the time, should not use "bizarre and strange jargon;"[46] and he should not "prescribe medicines and cures involving a whole range of unusual ingredients bearing unusual and strange names."[47] In Del Chiappa's opinion, in order to avoid behaving like a mountebank or quack the doctor had to abandon "that scholastic language created only by pedants and well designed to conceal the ignorance and mediocrity of certain doctors. But it is not sufficient for the doctor to employ clear and clean language in a way that any noble artist would. Nothing that he says should be sophisticated or mysterious. This would be a sign of a lack of skill and competence, and perhaps of a corrupt or bad heart, vices which should be avoided to the very utmost because they are detestable."[48]

And after observing that the word of the doctor is the first instrument with which he "combats" illness, this author once again criticized those doctors who speak in an obscure fashion. "If a doctor is a charlatan, declares Menandrus, then he is a new affliction for the sick man. A doctor who has a grotesque or mysterious way of speaking imparts a new and even worse illness to the patient. Whereas the first with his tricks can at times displease some people, the second, by speaking in riddles, pleases no one and irritates and sickens everybody."[49]

Professor MASSIMO BALDINI
Professor of the History of Philosophy at the University of Perugia, Italy

Notes

1. CF. D. J. DE SOLLA PRICE, *Sociologia della Creatività Scientifica*, translated by Roberta Rambelli, (Bompiani, Milan, 1967).
2. CF. R. K. MERTON, *La Sociologia della Scienza*, edited by M. Protti, (Angeli, Milan, 1981).
3. On this question see the following works: MARIA LUISA BETRI, *'Il Medico e la Paziente: i Mutamenti di un Rapporto e le Premesse di un'Ascesa Professionale* (1815-1859), in F. della Peruta (ed.) *Malattia e Medicina*, Einaudi, Turin, 1980), (History of Italy, 7), pp. 209-232. Ibid., *'La Crisi del Ruolo Medico.* I Galatei dell'Ottocento', in Federazione Medica, 1987, XL, 7, pp. 685-688.
4. MARIA LUISA BETRI, *Il Medico e il Paziente: i Mutamenti di un Rapporto e le Premesse di un'Ascesa Professionale (1815-1859),* op. cit., p. 209.
5. See R. SAVA, *Sui Pregi a sui Doveri del Medico*, (Martinelli, Milan, 1845).
6. G. DE FILIPPI, *Nuovo Galateo Medico Ossia Intorno al Modo di Esercitare la Medicina*, (Pasquale Pagni, Florence, 1839), p. 15.
7. *Ibid.*, p. 12.
8. *Ibid.*, p. 7.
9. R. SAVA, *Sui Pregi s sui Doveri del Medico*, op. cit., p. 154.
10. *Ibid.*, p. 10.
11. *Ibid.*, p. 11.
12. *Ibid.*, p. 113.
13. *Ibid.*, pp. 105-106.
14. Cf. E. BASEVI, 'Degli Uffici del Medico', in *Giornale Critico di Medicina Analitica*, 1826, II.
15. G. DE FILIPPI, *Nuovo Galateo Medico*, op. cit., p. 5.
16. R. SAVA, *Sui Pregi a sui Doveri del Medico*, op. cit., p. 30.
17. *Idem.*
18. G. DE FILIPPI, *Nuovo Galateo Medico*, op. cit., p. 159.
19. MARIA LUISA BETRI, *Il Medico e il Paziente: i Mutamenti di un Rapporto e le Premesse di un'Ascesa Professionale (1815-1859),* op. cit., pp. 217-218.
20. A. RANZI, *Delle Principali Cagioni Che Portarono la Decadenza dell Professione del Medico*, (Florence, 1851), p. 23.
21. O. TURCHETTI, *Dell'Influenza delle Scienze Mediche sull'Incivilimento ed il Ben Essere dei Popoli e dell'Attuale Infelice Condizione dei Medici*, (Pistoia, 1839), p. 56.
22. D. B. G. R., *Galeteo di Un Morto e Commenti di un Vivo Ossia il Galateo dei Medici*, (Placido Maria Visaj, Milan, 1829), p. 22ss.
23. G. DE FILIPPI, *Nuovo Galateo Medico Ossia Intorno al Modo di Esercitare la Medicina*, op. cit., p. 73.
24. A. DECHAMBRE, 'Déontologie', in *Dictionnaire Encyclopédique des Sciences Medicales*, (Masson, Paris, 1882), t. 27, p. 489.
25. S. DE RENZI, *'Sui Mezzi di Migliorare l'Educazione Medico-Chirurgica in Italia'*, in *Corrispondenza Scientifica in Rome*, (1847), p. 15.
26. R. SAVA, *Sui Pregi e sui Doveri del Medico*, op. cit., p. 26.
27. G. DE FILIPPI, *Nuovo Galateo Medico Ossia Intorno al Modo di Esercitare la Medicina*, op. cit., p. 139.
28. *Ibid.*, p. 68.
29. L. PETRINI, *Galateo de' Medici*, (Tipografia Grossiana, Aquila, 1924), p. 18.
30. A. KNIPS MACOPPE, *Centum Aphorismi Medico-Politici*, in popular form by Tito Berti (Casamassima, Patavii, 1991), p. 35.
31. *Ibid.*
32. *Ibid.*, p. 67.
33. S. MANDRUZZATO, *Galateo Pegli Ammalati*, (Stamperia Mazzoleni, Bergamo, 1821), p. 19.
34. *Ibid.*, p. 23.
35. *Ibid.*
36. F. COLETTI, *Galateo de' Medici e de' Malati*, (Padova, 1853), p. 13.
37. *Ibid.*, p. 16.
38. G. A. DEL CHIAPPA, *'Dell'Eloquenza del Medico'*, in Del Chiappa, *Raccolta di Opuscoli Medici*, (Tipografia di Pietro Bizzoni, Pavia, 1828), vol. 1, p. 107.
39. *Ibid.*
40. *Ibid.*
41. *G. Giacomini, 'Riflessioni Intorno al Linguaggio dei Medici'*, in *Memoriale della Medicina Contemporanea*, 1840, vol. III.
42. A. KNIPS MACOPPE, *Centum Aphorismi Medico-Politici*, op. cit., p. 55.
43. *Ibid.*
44. *Ibid.*, p. 37.
45. *Ibid.*
46. R. SAVA, *Sui Pregi a sui Doveri del Medico*, op. cit. , p. 101.
47. G. DE FILIPPI, *Nuovo Galateo Medico Ossia Intorno al Modo do Esercitare la Medicina*, op. cit., p. 26.
48. G. A. DEL CHIAPPA, *Dell'Eloquenza Medica*, op. cit., p. 108.
49. *Ibid.*, p. 130·

DOMENICO DI VIRGILIO

The Doctor: A Man for All

Introduction

"The Doctor: A Man for All" is the subject of my paper and it is certainly unusual. We might also say that it is an idea which is not often thought about, and perhaps which is new for most of us. This is because although the figure of the medical doctor has been analyzed, indeed considered in all its various aspects ranging from the scientific to the professional and from the historical to the artistic, what I will seek to do today is to stress that it has received very little attention in scientific assemblies and literature. Unless, that is, you have not had the opportunity to hold in your hands a copy of a book of over two hundred and fifty pages which was published in 1972, but which is not now to be found. That book was written by the then Monsignor Fiorenzo Angelini and bore the title of this paper. I could perhaps stop here and ask you to read it. You would find it a complete, interesting, and incisive work which discusses the medical doctor from this point of view in a very special way. It presents us with an unknown face of this professional figure which over the centuries, and long before Hippocrates, had and has had a unique and irreplaceable role in the life of every individual.

And the introduction to this subject, which in the few minutes available to me I will seek to present more in terms of images than through a series of logical steps, is dedicated to a presentation of this book: "Those who have had the opportunity of habitual contact with the medical world and its constant relationship with the world of suffering, well know—leaving aside factious or partisan perspectives—that the medical doctor is and remains a man for everybody, a man of whom everybody, in actual fact or in a possible future, has need.... Called to defend life, the doctor more than any other knows the fragility of man and at the same time perceives that spring of hope whose intense longing is often entrusted to the responsible exercise of his profession....

If the doctor is a man for everybody he is also a man whom everybody should get to know better."[1]

And if we go back in time we can see that in the *Iliad* one of the heroes of that poem by Homer utters a sentence which is indeed very significant: "The doctor is a man who is worth many men."

The medical profession has always placed itself at the service of man, although obviously enough it has done this with the limitations imposed by the environment and by the various cultures of different peoples. Because the service rendered by medicine affects men in what they share more than anything else, namely pain and suffering, the medical doctor can in a very real sense find in his vocation and in the exercise of his profession an edifying impulse which allows him to express himself beyond the most difficult defeats and trials.

For this reason this very special professional figure has been an integral part of the human experience during the history of the whole of mankind. This is true whether he has been a magician or a wizard, a medicine man, a priest or a scientist. The figure of the doctor has involved a special charisma invested with an aura of mystery, but above all else it has been an inevitable point of encounter between the needs of the suffering man and the healing powers of an individual who is always a man but at the same time is always endowed with special powers. Thus it is that in the medical doctor, as in the many-faceted surface of a diamond, hopes and anxieties and the torments and the calm of human suffering are refracted, but at the same time friendship and respect, trust and admiration, expectations and hopes, are also all fused.

And the "man who is a doctor," despite the centuries-old events of the human experience, remains unknown. This is because in the greatest and most beautiful events he bears within himself the mysterious sign of cooperation with the Creator himself in the preservation of life.

1. A Man First and A Scientist Second: The Response to a Call

What leads a young person to become a "medical being"? And what is the "formation" of this professional during the years of university and then, in constant fashion, during his professional life?

It is certainly true that the wish to follow the example of a family relative is frequently evident. A yearning for a position of prestige and respect within society is also often influential. But this certainly does not constitute the most important motive for the choice of a profession which has at its base the ability to respond to needs which are full of ethical value and of suffered solidarity, needs which must find within the soul of the young person that readiness to help which rises above the technological and scientific aspect of his training and formation.

Thus it is that the years of study are a crucial and delicate moment for university teachers who should ensure that the sole goal aimed at is constantly evident, namely service to man. There is thus a need to know how to link technological and scientific notions with the human require-

ments which are indispensable to the successful creation of that relationship between doctor and patient which is the forerunner to success in every action and work of treatment and care.

In the post-modern era in particular, with this frenzied technological progress, and much more than in the past, there is an especial need for university teachers to dedicate themselves to the formation of a "professional conscience."

Indeed, it is daily demonstrated that where this formation has been neglected during the years of university study or during the first years of the practice of the profession, it is very difficult to acquire that formation in the years thereafter.

"The scientific and professional skill of the medical doctor in itself is not enough to create an interpersonal relationship which is authentically human." The future doctor must be forged in qualities which will let loose talents which are necessary to his profession, such as:

An ability to listen which acts to create a climate of trust, acceptance and welcome which in its turn promotes a close link between the two key elements in medical practice;

empathy, the ability that is to say to put oneself in the shoes of the sick person and accompany him in emotional terms as well during the course of his illness;

sympathy, the ability that is to say to tune into the patient and enter into his feelings and his state of mind, but at the same time always maintaining a suitable distance from his inner condition;

respect for the other person, something which involves accepting the sick person for what he is and not for what we would like him to be;

awareness and respect for those moral values which determine the interior goodness of the individual."[2]

But over the last decades, at least in Italy, the human and ethical formation of the medical doctor has been neglected and this a has created a "vacuum" which at one time was at least in part filled by the human teachings of the young doctor's principal guide. This figure is by now someone who almost belongs to the past, but when present he was not only a source of scientific knowledge but also of behavioral and human wisdom. The old masters in the daily life of the hospital experience not only helped young doctors to grow in a scientific sense but also acted as guides in their lives.

To state the point in general terms, the formation and training of the medical doctor should not confine itself to scientific matters alone but should also be directed towards the formation and training of the individual himself. "We should thus ensure that the doctor and before him the student have a full awareness of the triple dimension of professional competence which does not only consist of *knowing* and *knowing how*

to do things but also of *knowing how to be*. This means a capacity for relationships, for understanding the value dimensions which underlie the human being, for respect for life, for an adequate psychology, for "friendship towards man." As an old aphorism of the Hippocratic school declared: 'Where there is love for man there is also love for art (medicine).'"

Today, however, the feeling of personal dedication to one's fellow men runs the risk of becoming clouded in the conscience because of the obstacles which can place themselves between the spirit of the medical doctor and the spirit of the patient. These are obstacles which are prevalently of a technical and technological character which are imposed by society and by the rules of the profession. But even in the most unfavorable and depersonalizing conditions *the medical doctor remains a man* who places his intelligence, his culture, his sensitivity and sensibility, and his heart, at the service of another man who suffers.

And the more conditions become difficult and even critical, the more there is a need for the medical doctor to recover and rediscover within himself that freshness and vitality which will one day guide his choice and his initial vocation.

2. A Man at the Service of his Brothers and Sisters

"Who is my neighbor?"

It has often been said that mankind passes through the hands of the doctor without discriminations of any kind and with a total abandonment sustained by the conviction that a man will be encountered who will know how to understand, share and take part in his requests for health—capable, that is to say, of "taking care of him in a moment of a very special kind where the doctor has to pay attention to the uniqueness and unrepeatable character of the suffering person. An encounter between trust and conscience, the trust of man marked by suffering and by illness and therefore in need. This man entrusts himself to another man who takes his need upon himself and goes towards him so as to help him, treat him, and heal him...this needs love, readiness to help, attention, understanding, sharing, benevolence, patience and dialogue."[3]

It seems on the other hand paradoxical that it is precisely at the moment when we have before us the most spectacular successes of medicine that the traditional and fundamental figure of the doctor is ever more bowed and weakened. This figure is increasingly called into question because of the ever greater impact of technology, a diminishing presence of "humanity," and his apparent transformation into a user of technology and standard actions which are separated from their indispensable ethical content. The risk of this is that the relationship of trust which has acted as the fulcrum of the medical art will be put into a state of crisis and that these two poles instead of interacting will end up by not understanding each other or finding themselves in opposing and opposed

positions. Why is this so? Why?

Allow me, as well, to refer to the parable of the Good Samaritan—a parable which over the last few days has often been cited and commented upon—in order to find an answer to these many "why's."

This parable, clearly enough, shows us which charisms and which virtues must shape and form the man who is a doctor. It is not for him to pass by with indifference. On the contrary, he must stop, and stopping does not mean curiosity, opportunism, or conventional gestures. It means, rather, readiness to help and understanding, and these must become a stimulus to action which seeks to help the other man who, as John Paul II makes clear, "cannot find himself fully unless he engages in the sincere giving of himself."

Compassion is not enough if it is not active and effective, and technological-scientific help is not enough if it is not inspired by compassion—that is to say, by a fraternal love which shares the suffering of the other person. For the Samaritan, the wounded man whom he helps, before being a stranger and an enemy, is somebody who is unknown. And yet the Samaritan recognizes that he is a man!

It is in this meeting, which is so intense and shared, that compassion is given. "On the one hand, it expresses a psychological attitude of readiness to help which is born not from an emotional impulse but from a rational conquest represented by an acquired knowledge of the common destiny written into the history of men. On the other hand, it manifests itself in a practical expression of a series of gestures and actions directed towards welcoming and communication.

This complex patrimony of activity certainly does not exclude forms of care and the development of operations which are strictly therapeutic in character, but they also include those forms of behavior which are well suited to making the sick person accept his own suffering and not reject the value and worth of his own existence even though afflicted and struck by evil. They also allow him to express a will to liberation and redemption through pain.

In this way, although the salvific value of suffering is a conquest of faith and of Christian culture, nonetheless it is also true that through the discovery of the human dimension of illness this line of thinking can assist both believers and non-believers to help man rediscover himself.

If suffering and pain are direct expressions of the life of man, that is to say essential manifestations of his human character and not tiresome and passing accidents to be canceled out, any form of activity which touches or meets these phenomena will take part in their human character and help in the discovery of what it is to be a human being."[4]

Emotional participation in the suffering of the patient, the understanding of his weakness as an excluded person, either temporarily or permanently, in its positive form expresses itself in the feeling of "*compassion.*" And a development of the ability to be compassionate means an improvement in professional capacities and expertise.

3. Listening—Readiness to Help and Sharing

Listening is certainly one of the most effective ways of establishing a certain feeling and affinity between the patient and the doctor. It also expresses great respect. When we feel that we are listened to, we feel the warm sensation of being taken seriously and thus of being worth something in the eyes of the person we are speaking to. At the same time, we feel we are able to forge a relationship whose nature is liable to provoke special reactions because the people involved are affected by the implications of physical intimacy, the dramatic quality of feelings caused by situations which may also be tragic, and by contact with pain and death.

By listening carefully to the sick person, the medical doctor can gradually enter into his world. Paths which would otherwise remain closed open up and enable the doctor to understand feelings which are present and to grasp the meaning of those feelings. The case-histories which we construct, when we are often distant from the patient, are in reality the history of a man asked to analyze his life. At times he brings it from the deepest part of his inner self and offers it trustingly to another man so that diagnoses and remedies can be produced.

It is from listening that suitable communication is born, whether of an oral or a non-oral character (at times what meaning is expressed by moving and intense silences expressed by gestures and emotions which are beyond words!).

It is a common view that the sick person can have the most suitable medicines and instruments available, the most advanced forms of competence of health care workers at his service, and the full satisfaction of his most immediate needs, yet at the same time all this is not enough. This is borne out by his frenetic desire to speak, to be understood, to be informed about his condition, and the psychological dependence caused by a condition of inferiority which often ends up by seeking to please as a sign of deference. And yet enough emphasis is never placed upon the importance of dialogue, of the personal concern of the medical doctor who by engaging in behavior which is understanding and tolerant is able to overcome the rejection of long and monotonous treatment of the patient and to exercise that function which has been defined with the phrase: "personal placebo."

A readiness to help is the key part of professional capacity and competence because it is a complex virtue which is made up of altruism, patience, psychological and physical

resistance, preparation and training for certain situations, and perseverance. In an essay entitled "*The Doctor as Communicator,*" published in the journal of the American Medical Association, the journalist Norman Cousins writes as follows: "Doctors and writers have at least this in common—communication is an important part of their activity. In the treatment of sick people the words used by the medical doctor have a profound effect upon their well-being. The words of the doctor can open doors or close them violently. They can open the path to cure or create a sick person who is dependent, trembling, frightened and hostile. Doctors are asked to pay attention to the individual, to dialogue, to solidarity and to be experts in humanity. Furthermore, they must communicate in a way which relates to the personal history of the patient. They need to enter into the history of the sick person with that discretion and love which makes them sensitive to all nuances and influences. Respect for the sick person also amounts to an ability to engage in progressive and delicate communication. The right words can raise the morale of the sick person; they can increase his will to live. The wrong words can provoke a sense of desperation and defeat, and diminish the effectiveness of any treatment which has been prescribed."

Indeed, the doctor would not correspond fully to the ideal of his vocation if in his use of the most recent advances in medical practice and science he did not also employ—in the practice of his profession—intelligence and ability, and, above all, his heart as a man.

"Suffering, which is present in different forms and levels of intensity in all men, is also present to release love from man, a love which expresses itself in the disinterested giving of one's own self in favor of other individuals who suffer." And "suffering men become similar to one another through the similarity of the situation, the trials of destiny, or through the need for understanding and concern, and perhaps through the constant question about the meaning of suffering." (Apostolic Letter *Salvifici Doloris*, February 11, 1984).

4. Man—Doctor—Catholic

"If the spirit of elementary humanity and natural love for one's fellow men stimulates and guides each conscientious medical doctor in his research, what would the Christian doctor be able to do if, moved by divine charity, he strove to do his utmost without sparing himself or the care and treatment he provided for the good of those he rightly and in conformity to his faith perceived as his brethren?"[5].

This is a powerful invitation to know how to link the parameters of science with those of the spirit, in the

knowledge that the authentic values of the gospels do not hinder but actually widen the perspectives of a science which is always dedicated to the service of man.

In his message to the Italian Catholic doctors at their eighteenth national conference in October 1988, which was held at Florence, John Paul II declared: "In devoting oneself to care and treatment of the body the Catholic doctor cannot and must not ignore the problems of the spirit, because the object of his work is the individual as a whole. For this reason his "ministry" must be carried out not only with professional and scientific skill but also with personal participation in the actual situation of each individual patient."

For the Christian doctor, therefore, the mere recognition of the humanity of the patient is not enough. The final objective is the establishment of a relationship with him which has an even deeper dimension and involves specific motives which are rooted in his faith. From this point of view the medical doctor must adopt an attitude of deep respect, of authentic humility, and of the greatest possible level of sharing, and all this in the full awareness of the interdependence of two roles. It may be added that it would be wrong on the part of the medical doctor to judge which of these two roles gives the most and which role receives the most.

No doctor can be of help and set an example without a deep inner life, without constantly referring to the reality of the suffering Christ!

"Luke, whom St. Paul called "beloved doctor," wrote in his Gospel: "when the sun had gone down, all those who had sick people, afflicted with different kinds of illnesses, took them to Him and He placed his hands on each one of them, and healed them." Without, obviously enough, having such prodigious virtues, the Catholic doctor, who is really that which his profession and his Christian life demands, will see all forms of human misery create a refuge around him and call upon his good hand to reach out and be placed over them."[6]

Your task "cannot be merely a matter of correct professional behavior and endeavor. It must be sustained by that inner attitude which is rightly called 'spirit of service.' The patient, indeed, to whom you dedicate your care and treatment, your studies, is not an anonymous individual to whom you must apply the fruit of your knowledge. He is a responsible person who must be called upon to be a participant in the improvement of his health and the achievement of a cure. He must be put in a condition to be able to make personal choices rather than be forced to accept the decisions and choices of other people." And John Paul II went on: "At a practical level each of you cannot confine himself to be a doctor of organs and physical apparatuses. He must be responsible for the whole person, and for the interpersonal relationships which contribute to the well-being of the patient."[7]

"Indeed, experience teaches us that the man who is need of care and treatment, whether of a preventive or a therapeutic character, demonstrates

needs which go beyond the organic pathology which is present. From the medical doctor he expects not only suitable care and treatment...but the support of a brother, a brother who knows how to make him share in a vision of life in which he can also find a meaning to the mystery of suffering and death.

"But the doctor inevitably comes up against pain and death in his scientific research and it appears to him as a problem to which his spirit does not have an answer. He also encounters death and pain in the practice of his profession and it appears to him as an inevitable and mysterious law in relation to which his art is often powerless and his compassion is sterile.

He is well able to formulate a diagnosis based upon elements derived from the laboratory or clinic, or present a prognosis based upon the requirements of science. But in the depths of his conscience, in his credo as a man and as a scientist, he feels that the explanation to that enigma continues to elude him. He suffers because of this. It worries and grips him inexorably until that moment when he asks for an answer from his faith, and this answer, although not so complete as it is in the mystery of the plans of God, will become clear in eternity, and at the same time will act to calm his spirit.

"And how can we justify the *powerlessness* of the remedies which science proposes to the relatives of the sick man? It is here, in this dramatic and sublime moment which is unique in its specific character but so often to be repeated, that the medical doctor takes off his professional uniform and re-emerges as a man with his inner capacity for sensitivity and sensibility, solidarity, and humanity—the only paths by which to create acceptance and serenity.

"But only a heart penetrated by a living and deep faith will be able to find the tones of sincerity and conviction which will be able to ensure that 'transcendental' answers are received in positive fashion."[8]

Conclusion

The medical doctor is certainly the man who keeps the largest number of human secrets. Acting through the instruments of science and technology which he has available, the physician looks at the man who is behind the illness or ailment. It is this gaze to the beyond which gives such a profound and completely human meaning to the art of medicine and enables him to achieve a correct distinction between service of man to man and the subservience of man to man.

The medical man and scientist must know how to express himself entirely not only through drawing upon necessary technological knowledge but in particular through a clear vision of man, his dignity and his purpose, and of that solidarity which links patient and doctor and makes them become two inseparable parts of a shared effort aimed at affirming and defending shared humanity.

More than any other professional figure, the doctor has an opportunity to observe individuals liberated from illness but not healed in their souls. In the same way he will experience defeat both intensely and with deep regret when he is confronted by unchangeable afflictions, but at the same time will be able to understand that man can raise himself to a wider and more sublime context through the projection of his pain into the sphere of the transcendental.

Because medicine by definition is service to life, a man's profession and his conscience come together in this service. And because the task of the doctor is first and foremost to serve the life of his neighbor, the professional conscience touches upon love and charity when the doctor's conscience is placed near to that of people who are sick.

In this encounter "the doctor must be aware of the limits of the look, the face and the situations of the sick person he is called upon to treat. He is the best synthesis of the complexity of the evil which draws upon the roots of the body and the spirit, which embraces the person in both a local and an overall sense, which involves the whole life of the patient in suffering.... And it is precisely this opportunity of perceiving man in his unity and of placing him in his totality, which gives rise to the subordination or rather the cooperation between medical science and ethical evaluation to such a degree that the doctor can in certain moments perceive almost visually the need to turn to the moral conscience before proceeding to act with the means and instruments of his professional skill and expertise."[9]

The saint and doctor Giuseppe Moscati declared: "Blessed are we doctors, who are so often unable to defeat an illness; blessed are we if we remember that in addition to bodies we have before us immortal souls, and that the evangelical precept enjoins us to treat them as we would treat ourselves. Herein lies the true satisfaction rather than hearing ourselves proclaim that we have cured a physical evil when for the most part our consciences remind us that in actual fact the affliction cured itself."

When Albert Schweitzer was thirty years old and decided to embrace the medical profession, answering thereby a distant call which was lost in the paradise of his childhood, he declared that only by taking this path would he really be able to fulfill his great dream of full service to life.

Replying like Schweitzer to an ancient call, the medical doctor knows that he will be called upon by all kinds of people without distinction: believers and atheists, rich and poor, lowly and powerful. He does not want to knock at doors because he knows that he will have to answer people's requests first and foremost as a man and brother, and only secondly as a professional and as a scientist. His hope, as Pius XII wrote in his marvelous prayer for doctors, is that "we are fraternal in comforting, sincere in giving advice, caring in providing treatment, distant from giving disappointment, and gentle in announcing the mystery of pain and death."

Professor DOMENICO DI VIRGILIO
Member of the Pontifical Academy for Life, Chief Physician, President of the Catholic Medical Association of Italy, Consultor to the Pontifical Council for Pastoral Assistance to Health Care Workers

Notes

1. F. ANGELINI, *Il Medico un Uomo per Tutti* (Orizzonte Medico, 1972).
2. A. DE NATALE, "*Fenomenologia ed Eticità della Relazione Medico-Paziente,*" in *Bioetica e Cultura*, IV, 1995, 7, pp. 55-71.
3. *Carta degli Operatori Sanitari*. Pontificio Consiglio della Pastorale per gli Operatori Sanitari.
4. V. SARACENI, *Orizzonte Medico*, no. 2, 1984.
5. PIUS XII to the Fourth International Congress of Catholic Doctors, Rome, September 30, 1949.
6. PIUS XII to the Medical-Biological Union of St.Luke, November 12, 1944.
7. JOHN Paul II to the Fifteenth World Congress of the FIAMC, Rome, October 5, 1982.
8. PIUS XII to the Medical-Biological Union of St. Luke, November 12, 1944.
9. F. ANGELINI, *Il Medico, un Uomo per Tutti*, pp. 151-152.

IGNACE DE LA POTTERIE

The Biblical Icons of Life

Introduction

We are taking part in the tenth international conference to be organized by the Pontifical Council for Pastoral Assistance to Health Care Workers. It is clear from the title of this conference that an immediate, concrete and practical goal is aimed at. This explains why a biblical scholar has been invited to prepare a paper which has a similar goal—"the biblical icons of service to life." A reflection upon the medical ethics and situations of "*health* service" is undoubtedly what the author of this paper is called upon to present.

But it must be pointed out that for a biblical scholar a direct use of the bible for such an endeavor would be impossible. I am thinking here of the classic statement on the four meanings of the bible outlined by the *Catechism of the Catholic Church* (nos. 117-118): to the historical and literal meaning of the bible must be added the spiritual meaning, a meaning which in turn has three sub-divisions. Certainly there is the moral meaning which according to the old rule tells me "what I should *do*"). Yet this moral meaning is neither the first nor the principal meaning.

Indeed, it must be preceded by the search for the symbolic and typological meaning ("that which I must *believe*"). However this meaning must also be open to the future through the anagogical meaning ("what I must *move* towards"), that meaning which shows us the eschatological purpose of the great events of salvation. This, according to great Tradition, provides us with the real interpretation of the scriptures—the search for the both profound and total meaning of the Word of God. This Words is open at one and the same time to the *past*, to the *present*, and to the *future*.

Probably unknowingly, it is towards this truth that the first two key words of the title of this paper really direct us—the "biblical icons." This is because in Christian art icons act to represent all the great stages of the history of salvation—the Old Testament, the time of Christ, the inner condition of the believer, and the eschatology. They do this precisely in order to reveal the unity and *integral meaning of* these stages to the Christian. It is in this spirit that I will conduct my investigation into the meaning and significance of these two first words. The exact title of my paper will thus be: "the biblical icons of life."

But in what sense?, above all, I will examine the question of what a *painted icon* really is, and this investigation will be based upon a long tradition of the Eastern Church which is however presently being rediscovered in the West. In the second part of the paper there will be a presentation of the principal "*biblical icons* of life," that is, I will seek to explain the message of certain essential figures of the history of salvation. These figures direct and orient us towards the mystery of life and thus come to be portrayed in the icons of Christian art.

To begin with there are Adam and Eve, our first ancestors, present at the beginning of the whole of human history. Then there is Abraham who became the father of the people of Israel and the point of departure for the genealogical tree which would lead to the Messiah. Obviously enough, at the center of the history of salvation we find Jesus, the Son of God made flesh, who was himself "the life" and "the light of the world." But we should also refer to Mary because it was through her that the Incarnation was able to take place; and it is also Mary who at Cana is presented as the bride of the Messianic wedding and is described at the cross as the mother of the Church. And it is Mary who in the Apocalypse becomes the women dressed like the sun, the image of the Church which is to be the Bride of the Lamb in the Jerusalem of Heaven. Furthermore, it is Mary who invites us to drink always of the water of life—that is, to live from the life of God.

There are therefore four biblical icons in all—two from the Old Testament and two from the New Testament, but they all belong to the same eschatological perspective. And it is certainly no accident that it is principally these last two figures—Jesus, the Son of God made flesh, and Mary the Mother of God—who have been represented and portrayed over and over again in Christian icons in order to provide for our inspiration and our guidance. At the end of the history of salvation, therefore, it is *life* which will triumph.

1. The Icon

What are the essential characteristics of a Christian icon?

1. Symbolism is of primary and fundamental importance. Through the pictorial representation of a biblical figure the icon invites us to examine and discover the mystery and inner meaning of that figure. It is for this precise reason that an icon is different from a painting and different from very many religious or pious images which merely represent Christ, the Virgin, or the saints and their human features. An icon, on the other hand, as we have said, is an "image of the invisible,"[1] "a symbol (or an expression) of the spiritual world."[2] The ultimate basis of an icon of Christ is the Incarnation of the Son of God. In his fine book entitled "L'Icône du Christ," Von

Schönborn expresses this idea in the following way: "God visible to our mortal eyes: this is the central and unique event which characterizes the meaning of the icon of Christ (eikôn). Jesus Christ (said St. Paul) "is the image of the invisible God" (Col. 1:15)...The God who cannot be understood provides a perfect image of himself, his Son...and it is for this reason that Jesus can say: "Whoever has seen me, has seen the father" (Jn 14:9). A human face has thus become the perfect expression of the Son of God."[3]

But for this to be possible (according to the passage from John which has just been cited), beyond the human features of the face of *Jesus* the disciple should also discern and discover, through faith in Jesus, the "splendor" of this face, the face of the *Son* turned towards the Father (cf. 1 Jn 1:2), and the face of he who "sees the Father" (Jn 6:46). This importance of the Incarnation was explained very well and in very precise terms by Maximus the Confessor during the battle for the acceptance of icons: "Through the Incarnation the Lord becomes his own predecessor...He becomes his very own type and symbol which *he himself manifests,* he leads the created being towards himself because he is *unfathomably hidden.*"[4]

What was at one time true (at the time of the historical Jesus) for the Word which was made flesh amongst us, is equally true in the Church in relation to the icon of Christ which portrays him. From that moment, Von Schönborn, observes: "the contemplation of the icon means opening ourselves to this purifying and sanctifying Mystery of the Incarnation. Because of this reality the icon is the most evident and telling sign of the Economy."[5]

2. With regard to other icons, it should be pointed out that here also the contemplative gaze must seek to penetrate the mystery of the person which the icon portrays. We can think for example of the icons of the Virgin, the Mother of God. Let us listen to what Léonide Ouspenski has to say on the subject in his "*Essai sur la Théologie de l'Icône."* In this work he wants to establish and bring out the difference between Western religious art and Eastern icons (the quotation is from T. Spildlik): "Making a comparison between the "*Madonna del Granduca"* by Raphael and the Russian icon of the Theotakos, Ouspenski concludes: the great Italian artist (Raphael) offers us a gracious woman with a wonderful child. He knows how to say sublime things about their mutual love and their human relationship. But he does not tell us that this woman is the Mother of God and that that child is divine."[6] This judgment is certainly too severe on Raphael in the opinion of another great expert on Russian icons, Pavel Florenski[7]. Whatever the case may be, this comparison helps us to understand in clearer fashion that there cannot be a real icon without reference to the spiritual dimension of the image which has been painted, an image which is itself an expression of the spiritual experience of the artists who painted the icon.

3. Another point should also be made, and this relates to the analogy between the painted icon and the written passage from the bible. According to the Second Council of Nicea, which in 787 witnessed the victory of Orthodoxy over iconoclasm, "the Holy Scriptures and the holy image...explain each other. A single testimony is expressed in two different ways: through the word and through the image, and both transmit the same revelation in the light of the same holy and living Tradition of the Church."[8] For this reason, the Council went on, "a veneration of an icon involves a correct understanding of the Holy Scriptures and vice versa."[9] One can see, therefore, why it is legitimate to talk in terms of "biblical icons," as indeed this paper has done. S. Boulgakoff, the great Russian specialist on Orthodoxy, declared that a word from the gospels is "a *verbal* icon of Christ." It follows from this that the way in which certain important figures from the Bible are portrayed in icons gives us a certain view of how we should understand these figures as they are presented in *texts* from the Holy Scriptures. The Tradition of the Church, therefore, comes down to us through two parallel access roads. This is especially true in relation to the icon of Christ. "The Council (of Nicea) thus brings word and image close together because both speak about the same thing: the icon, like the Gospel, belongs to the New Law."[10]

2. The Great Biblical Icons of Life

What I would like to do in this second part of the paper is (rather boldly) to trace the whole of the history of salvation so as to show that according to Holy Scripture all the key figures of this history, in essential terms, communicate the same message to us, namely the message of life, of a life which is participation in the life itself of God.

a) Adam and Eve

Let us call to mind first of all the fundamental biblical text which discusses the creation of the human being, the creation of man and woman: "So God created man *in his own image, in the image of God* he created them; male and female he created them." (Gn 1:27)

Life, therefore, is a participation in the life itself of God because men and women are made in the image of God. Life itself comes from God. For the human couple, the transmission of life promoted by men and women through marriage, means participation in the creative act of God. Amphilochios, a Greek bishop cited by the Pope in the Encyclical *Evangelium Vitae,* said that marriage is a "generator of humanity, a creator of images of God"[11]. It is for this reason that Genesis tells us that after the creation of man and woman "God blessed them, and God said to them, "Be fruitful and multiply, and fill the earth and subdue it" (Gn 1:28). One can thus also understand why later on in Genesis the bible narrates that "the man called his wife's name Eve, because she was the mother of all living" (Gn 3:20).

Yet it should be stressed that the Holy Scriptures form one great unity. The Old Testament must be interpreted in the light of the New Testament. The creation of Adam and Eve opens up a perspective on the time of salvation, upon eschatology and upon future life. Let us read once again some verses from St. Paul which come from the first letter to the Corinthians: "Mankind begins with the Adam who became, as Scripture tells us, a living soul; it is fulfilled in the Adam who has become life-giving spirit...; the man who came first came from earth, fashioned of dust, the man who came afterwards came from heaven" (1 Cor 15:45-47). A little earlier, in discussing the Resurrection of Christ, St. Paul wrote: "Christ has risen from the dead, the first fruits of all those who have fallen asleep...just as all have died with Adam, so with Christ all will be brought to *life.* But each must rise in his own rank; Christ is the first fruits...and the last

of those enemies to be *dispossessed* is *death*" (1 Cor 15:20, 22, 26).

In the vast evolution of the history of salvation which is presented through the whole of the Holy Scriptures, the final act will take place when God ensures victory over death and provides for the final triumph of life.

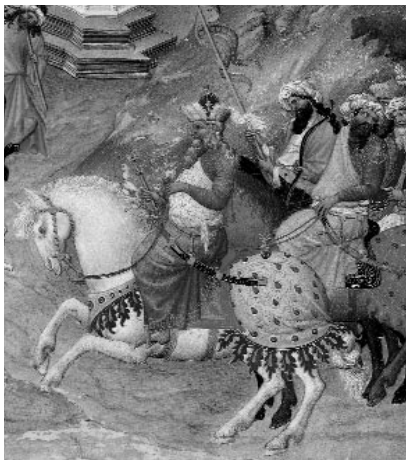
Such an orientation from the beginning until the end of Scripture, this prefigurative value of Adam who announces the coming of Christ, the last Adam, is what bible scholarship terms *biblical typology*. It is a term which also applies to Eve who announces and prefigures Mary, the new Eve[12], but here such typology also serves to emphasize the contrast between these two figures.

After the sin of the Garden of Eden, God informed the first woman that she would give birth to her children in pain (Gn 3:16). For Mary, *the new Eve*, this pain caused by sin no longer exists because with her begins the time of salvation. For this reason Mary was "transformed by grace" (*kecharitômenê,* Lk 1:28) prior to the Incarnation of the Son of God: she remained a virgin both when she conceived and when she gave birth to Jesus. This is what theologians call the *virginitas ante partum* and *in partu.* One can thus grasp the symbolic beauty and the theological profundity of the scene described by Romanus la Melòde (one of the greatest religious poets of the Eastern Church) in one of his hymns to the Nativity.

He uses a bold poetic vision and does not hesitate to describe Adam and Eve as being present in Bethlehem at the moment at which Mary beings Christ into the world. Eve reminds Mary that she herself, after the Fall, had to give birth in pain but she now renders homage to the new Eve, a woman transformed by grace who had given birth to the Son of God in a virginal state in order to achieve redemption from the divine malediction.[13]

b) Abraham

With Abraham begins the history of the people of God who would become the Church. Abraham and his immediate descendants, namely Isaac and then Jacob, are those whom Paul calls "the patriarchs" but when referring to Abraham immediately the Apostle adds: "and theirs is the human stock from which Christ came; Christ who rules as God over all things, blessed for ever, Amen" (Rm 9:5-6). Yet Paul is proud that he is an "Israelite myself descended from Abraham; Benjamin is my tribe" (Rm 11:1), even though he was called on the road to Damascus to become the Apostle of the nations. Indeed, he goes on to stress that "God has not rejected the people he chose." The pagans who convert to the faith take part in what the liturgy calls the *Israëlitica dignitas,*[14] namely that privilege of the nations which involves becoming "sons of Abraham" and participation in the dignity of belonging to Israel, a people deemed by Paul: "the Israel of God" (Gal 6:16).



Now, the "holy root" of Israel is Abraham, the origin of the people of God, made so because of the divine Election and the promises made to the Patriarch. But for Paul (Rm 9:8) and for John (Jn 8:31-37) the real sons of Abraham are not all those who descend from him in the flesh but those who, like Paul, accept the promises and live out *the faith* of Abraham, even though they may indeed come from pagan peoples. "We are all Abraham's children" (Rm 4:16), Paul is thus able to say. We are *all* the children of Abraham because even though in old age Abraham's body was already dead, and the womb of his wife Sarah was also dead, Abraham *believed* in God because "God can raise the dead to life" (Rm 4:17). The true children of Israel and true Christians are thus those people who live the promise made to Abraham and also live the faith of Abraham.

The decisive event in the life of Abraham was the Covenant which God made with him, and the paradoxical promises which God made to him: "for I have made you the father of a multitude of nations. I will make you exceedingly fruitful" (Gn 17:5). It is this promise which Christian icons often represent, as for example is the case of the famous icon by Roublev, an icon which has been described as the highest expression of Russian painting. It is a representation, as is well known, of the apparition at Memre when three angels came to the Patriarch to tell him that despite his old age and the infertility of his wife he would become the father of a great people (Gn 18:1-15). For Roublev the three angels represent the Trinity but because of their inseparable unity—a reality suggested in the icon by the circular composition of their silent relationship—the painter makes the observer understand that it is God himself who is sending this message to Abraham.

St. Ambrose explains that the mystery of the faith of Abraham lies in the fact that even though he sees three visitors it was in actual fact God who spoke to him: "*Deus illi apparuit et tres aspexit,"*[15] even though from the text of the Vulgate (Gn 18:2) the liturgy was to draw the formula, in Christian form, of "*tres vidit et unum adoravit."*

Yet "the genius of Roublev, as has already been observed, adds to the density of the message by centering the scene on the couple holding the head of the sacrificed calf (sacrificed by Abraham). Under the sadness-filled eyes of the two lateral figures, this becomes a chalice, the symbol of the Passion."[16] The symbolism of the three angels in the icon by Roublev thus directs us first of all towards the Trinity, but it also directs us towards Christology and towards the cross.

This symbolic vision suggested by the Russian icon helps us to understand more fully a mysterious word which is used by Jesus in the fourth gospel. During a conversation with the Jews about the descendants of Abraham, Jesus declares that he is the true object of the promise made to the patriarch, the real cause of his joy, the spiritual Isaac. In this way he directs towards his own person the Messianic joy of Abraham which was experienced when the latter came to truly believe that he would indeed become the father of Isaac and of the whole of Israel. This is undoubtedly what Jesus wanted to make clear to the Jews: "As for your father Abraham, his heart was proud

to see the day of my coming; he saw, and rejoiced to see it" (Jn 8:56). By opening himself in faith to the prospect of a fulfillment which was to express itself in Christ, Abraham became a biblical icon of *faith* in Christ.

But Abraham is even more directly an icon of *life*, and also of eternal life, according to certain passages to be found in the Gospel according to St. Luke. In reply to a cunning question posed by the Sadducees, people who denied the resurrection of the dead, Jesus referred to Moses: "the Lord the God of Abraham and the God of Isaac and the God of Jacob. It is of *living men*, not of dead men, that he is the God; for him all men *are alive*" (Lk 20:37-38). And in the parable of the wicked rich man and Lazarus the place of eternal life where Lazarus is taken by the angels is called "Abraham's bosom" (Lk 16:22) by our Lord, and this place is the final fulfillment of the whole history of salvation. Thus it is that in her liturgy for the dead the Church expresses her hope that all those who die will go to "Abraham's bosom," that is, to *eternal life.*

c) Jesus, the Son of God Made Flesh

And now we come to the central part of this paper. As has already been pointed out, the theological core of the icon of Christ is the Incarnation of the Son of God: the invisible became visible in Jesus, who was a man. In the development of icons, two scenes from the gospels were especially suitable to the expression of the symbolic force of a historical event in the life of Jesus—the Transfiguration on the mountain and the side of Jesus opened after his death on the cross.

a) In the Eastern tradition the most important icon of Christ was undoubtedly that of the Transfiguration which took place on Mount Tabor. It was the scene which each young artist had to paint after his technical apprenticeship and his spiritual formation, when for the first time he had to paint a real icon destined for worship. The reasons for this can be easily understood. Of all the episodes in the gospels the Transfiguration is that which involves the most important and forceful expression of the revelation of the future Easter and eschatological glory of Jesus.

This revelation was given to three apostles after the description of the future Passion. Let us read once again the account of this episode which is given by St. Mark in his gospel:

"Six days afterwards, Jesus took Peter and James and John with him, and led them up to a high mountain where they were alone by themselves; and he was transfigured in their presence. His garments became bright, dazzling white like snow, white as no fuller here on earth could have made them" (Mk 9:2-3).

According to Eastern tradition the icon expresses holiness but in such a way as to be made visible to our

physical eyes, made in the image of Christ. Let us quote L. Ouspenski once again: "Image of the sanctification of man, it represents the reality which is revealed by the *Transfiguration* of Christ on Mount Tabor." And he goes on to add the following liturgical commentary made by the Second Council of Nicea of 787: "Falling to the ground on the holy mountain, the greatest of the apostles prostrated themselves when they saw the Lord reveal the dawn of the divine light; and now we prostrate ourselves before the holy Face which shines forth stronger than the sun."[17]

It cannot be denied that in the gospel text the account of the Transfiguration is the most beautiful of the "*verbal* icons of Christ" (S. Boulgakoff). For this reason its symbolic richness would later be abundantly used in the *painted* icons of the East. The "dazzling white" to which Luke refers (9:29) would come to be fully represented in these icons. The revelation made to the apostles on the mountain during the fourteenth century was called the "Taboric light" in order to distinguish it from the unfathomable profundity of the essence of God.

b). The other episode from the gospels which deals with the life of Christ and which should be discussed here is that episode which is described in John 19:34. The evangelist tells us that while Jesus was still on the cross his side was opened by the spear of a soldier. To put it simply, this is not an example of an icon because the symbolic value of the event was developed and recognized more in the West than in the East. Indeed, in the West there was a widespread devotion to the heart of Jesus (e.g. the German mysticism of the Middle Ages and the revelations of Paray-le-Monial in the seventeenth century).

However the real point of departure for this long Latin tradition is to be found in the comment of St. Augustine on the passage from John. The core of that passage can be quoted here: "*One of the soldiers opened (aperuit) his side* with a spear. The gospel was careful in its choice of words. It did not say struck or wounded the side...but *opened.* It wanted to show at this point, so to speak, that the *door of life (vitae ostium)* had been opened; (without this) one cannot enter into *life*, into real *life*."[18]

A careful exegetic reading of the text from John enables us to perceive its symbolic value and its entire theological profundity. We have to begin with the passage itself. The *blood* which *flows out* from the opened side of Jesus symbolizes the profound life that he had led prior to his death, his total obedience to the Father, his love for his brethren, and his Messianic awareness that he had to fulfill the whole of Scripture and found the Church at that moment, in the persons of Mary and John. The *water* which *flows out* from his side, Hippolitus said, was "the water of the Spirit." It symbolizes that Spirit which Jesus, by his death, communicated to the Church ("tradidit spiritum," 19:30).

We should therefore say—and here we follow a universal tradition which is both Eastern and Western—that the Church *was born* on Calvary from the opened side of the new Adam. This interpretation is based first of all upon a nearness of this passage to a declaration made by Jesus at the feast of the tabernacle: "Fountains of living water shall flow from his bosom" (Jn 7:39), which John himself explained as being a

reference to the Spirit. The Church, therefore, "was born" directly from the wound in the side of Christ when she received the Spirit of Jesus. The life of Christ, from the moment of the cross onwards, was thus prolonged in the *life of the Church.* The open side of Jesus on the cross, for those who contemplate it in faith, really and authentically becomes "the door of life." It is for this reason that in the litanies to the Heart of Jesus the Church puts the following invocations on our lips: "Heart of Jesus, source of *life* and of holiness," "Heart of Jesus, our *life* and our resurrection."

4. Mary, Mother of Jesus and Mother of God

If Jesus is the door of life, Mary, his mother, she who gives us Jesus and leads us to him, is necessarily an important icon of life. And it is as such that Tradition has instinctively represented her on innumerable occasions in Christian art, both in the West and in the East. The two most important gospel scenes in this respect are: the telling of the good news to Mary (Lk 1:26-38) and the wedding feast at Cana (Jn 2:1-11).

a) With regard to the Annunciation, it should be stressed that we pay great attention to two essential aspects which are brought out by the evangelist and which we also find in Christian icons—the virginity of Mary and her motherhood. But her virginity is of primary importance. In his initial greeting the angel calls Mary *kecharitômenê*, a term which is wrongly translated into the Vulgate and in numerous modern translations as *gratia piena,* full of grace. Following the old Latin version prior to St. Jerome we should rather use the translation "infused with grace" (grata facta Deo). For a long time Mary had been "transformed by grace," a grace which had "made her find favor in the sight of God."

St. Bernard said that this grace was the grace of virginity. For a long time, because of this grace, Mary felt the wish to remain virgin, to live in a nuptial relationship with God. For this reason God prepared her for a form of motherhood which was to be virginal. But Mary had still not understood the whole of this mystery. For this reason she was troubled at the annunciation of her impending maternity. But when the angel told her that she would have "conceived in her womb" through the creative action of the *Holy Spirit* everything became clear and she gave her joyful consent. Mary thus became the chosen instrument of God by which to make the Incarnation of his son possible: Mary would at the same time and necessarily be both a virgin and a mother. It was for this reason that the angel told her that she would have "conceived *in* her womb," that is, that she would have conceived virginally. She would give life to a child whom she would call Jesus but who would be the Son of God. The fact that God himself was the father of Jesus and that Mary would become his mother in a virgin state is, in synthesis, the central mystery of our faith—that is, of the Incarnation.

But given that we are speaking about biblical icons let us now ask ourselves how these two aspects of the Mystery of Mary—that is, her virginity and her maternity, have been represented in Christian art. The variations are manifold. We can bring to mind two models which are especially evocative and indicative. With regard to the Italian Renaissance we think of the beautiful Annunciation which was left to us by Andrea della Robbia in a white and blue bas-relief which is kept at La Verna.

The virginity of Mary is expressed in this picture in three ways: the dove of the Holy Spirit is seen flying towards Mary and it is the Holy Spirit which will make her with child; Mary is next to a kneeling angel who speaks to her of a garland of lilies which symbolize her maternity; and at the top right of the picture there is God the Father, who is looking carefully at Mary. This makes us understand that the child she will bring into the world will be the Son of God, in other words, that God will be his Father. In Eastern icons the symbolism is more simple: the triple virginity of Mary is often represented by three stars on Mary's shawl. This virginity is present before, during, and after the birth of the child.

The representation of the maternity of Mary was clearly easier, and today it may even appear banal: there are so very many icons and so many paintings which have Mary and her child as their subject! Let us reflect, however, upon the fact that these very common forms of painting or icon belong to Christianity alone. Nothing of their kind is to be found in other religions. The reason for this is simple and lies in the fact that the Incarnation is a specifically Christian mystery. This is why they are so widespread. Furthermore, the symbolism which is used has to make the observer understand that this woman with a child in her arms is the Mother of God and her son is the Son of God. Let us now examine three icons of this kind, all of which portray the Virgin Mary.

First of all there is the type called *Galactotrofousa,* the mother who breast-feeds her child, a feature which clearly emphasizes the entirely human aspect of this maternity. Then there is the type designated *Eleousa,* or tenderness, where the Child is seen tenderly embracing his mother (for example, in the famous icon of the Mother of God by Vladimir) but where the expression of Mary is already tinged with sadness because she foresees the passion of her Son. Finally, and above all the others in importance, there is the frequent model of the *Odigitria* (from "hodos," or road) because with her right hand the mother points to her son, who must be the "road" which leads us to life (cf. Jn 14:6).

But in nearly all these three kinds of icons, and near to the halo which surrounds the head of the Virgin, there is an inscription which affirms the essential and unique role of this woman in the Christian mystery: *Mêtêr* Theou or *Theotokos,* "Mother of God." We can thus easily understand and grasp why the icons with Mary as their principal subject have become the icons *par excellence* of the Incarnation—that is, of the the anthropical mystery of the Son of God made man and of the completely real human maternity of a woman who was to become the Mother of God.

In Byzantine churches this icon is an evocation of the triumph of orthodoxy, which was achieved at the Second Council of Nicea of 787, a triumph which took place after the crisis caused by iconoclasm and the struggle against images, both of which had taken place during the eighth century.

b) A few more words on the second episode which has been cited, namely the wedding feast at Cana. Here a brief reference to the Old Testament is called for: the prophets often speak about the daughter of Zion. This symbolic woman represents the people of Israel and the role that she performs in the mystery of the Covenant. In essential terms she is the spouse of Yahweh, with whom

God formed the Covenant as though it were a marriage. But she is also called the Virgin Israel *(Virgo Zion)* in order to show that the daughter of God could not have any other husband, an act which would have involved her committing the adultery of idolatry. She is also Mother Zion for all the children of Israel who live in the Covenant. In the New Testament it is Mary who becomes "the daughter of Zion *par excellence*," as the Council declares. The prerogatives of the old Israel come to be expressed in her and she thus becomes the image of the new people of God, the icon of the Church.

But in what ways can the title of Bride also be applied to Mary? After all, she has been called *Sponsa Verbi, Sponsa Spiritua Sancti.* Here we must take as our starting point the description of the wedding feast at Cana given by John, an event which obviously has a deep symbolic significance. The wedding feast at Cana is a great symbol of the Messianic wedding. The real bridegroom of this wedding feast is Jesus, and the bride is the Daughter of Zion represented by Mary and the group of disciples.[19] The same reality would be present at the cross where Mary, with the favorite disciple, becomes "the newly-born Church." But this symbolism acquires its fullness only in the grandiose visions of the Apocalypse, and especially in chapter XII where we read of a "a woman that wore the sun for her mantel, with the moon under her feet, and a crown of twelve stars about her head" (12:1). This woman here is the archetype, the symbol, of the triumphant Church.[20] She is at one and the same time virgin, mother, and bride. And one thus understands why the Church, in the liturgy of August 15, applies this great symbol to the Virgin to celebrate her victory over the forces of evil and her assumption into glory.

But this symbolic vision acquires even greater breadth in the last two chapters of Apocalypse, chapters which describe the final eschatology, namely the definitive conclusion of the Covenant in the heavenly Jerusalem. The Holy City is described as "like a bride who has adorned herself to meet her husband" (21:2). This bride is the Wife-Church to whom we can give a human countenance, that of Mary in her glory. Later on she is called "the bride of the Lamb" (21:9). But let us read the passage by a powerful voice coming from the throne of God: "Here is God's tabernacle pitched among men...there will be no more death" (21:3-4). This is of great contemporary relevance given that John Paul II in the encyclical *Evangelium Vitae* condemns the culture of death which dominates the epoch in which we live. This is contrary to the deep dynamism which is present throughout the history of the Church and unifies the history of the Church. St. Paul said to the Corinthians: "the last of those enemies to be dispossessed is death" (1 Cor 15:26). And the Apocalypse communicates the same message: "there will be no more death" (Rv 21:4). The last message which Apocalypse gives us concerns life: "The Spirit and the bride bid me come; let everyone who hears this read out say, Come, Come, you who are thirsty, take, you who will, the water of life; it is my free gift" (Rv 22:17). This water of life we are invited to drink in the holy city is the life itself of God.

Let us seek to capture in a few words the immense journey we have taken down the history of salvation from the creation to the final eschatology. This long path enables us to understand the deep meaning of our existence as Christians: it is a constant journey towards life. Our first ancestors who were created in the image and likeness of God nonetheless committed sin. Yet God, although he indeed told them that they would die because of their sin, nevertheless promised them salvation. Later he told Abraham that he would become the son of the chosen people, the people who would give rise to the Messiah, the son of Abraham and the son of David but also the Son of God. From that moment the Messiah would become the life of the world and his side opened on the cross would become a source of the Spirit for the people of God, the door of life. Through his resurrection he would thereafter become the "one who is alive" (Lk 24:5). But it is Mary, with the Church that she represents, who invites us to receive this life, as is clear from the promise made to the Church of Ephesus: "Who wins the victory? I will give him fruit from the tree of life, which grows in the Paradise of my God" (Rv 2:7).

Rev. IGNACE DE LA POTTERIE, SJ
Emeritus Professor of the Pontifical Biblical Institute, Rome

Notes

[1.] Cf E. STENDLER, *L'Icône, Image de l'Invisibile*, (Desclée de Brouwer, 1982); or V. Melchiorre (ed.), *Icona dell'Invisibile. Studi per un'Interpretazione Simbolica di Gesù Cristo* (Milan, 1981).

[2.] T. SPIDLIK, *"L'Icône, Manifestation du Monde Spirituel,"* Greg, 61 (1980), pp. 539-554.

[3.] C. VON SCHÖNBORN, *"Art e Contemplation: Les Icône du Christ,"* in the volume of collected essays: C. VON SCHÖNBORN et al., *L'Art et la Technique. Die Kunst und die Technik* (Fribourg, Suirre, 1979), pp. 9-20 (cf. pp. 12 ff). By the same author there is one of the best works on the question: *L'Icône du Christ. Fondements Théologiques Elaborés Entre le I et le II. Concile de Nicée (325-787),* (Paradosis XXIV, Fribourg, 1976). For comments on the mysterious expression of John 14, 9, see my work: *"Chi Vede me Vede il Padre* (Jn 14, 9). Dalla Storia al Mistero," in AA.VV., *L'Ombra di Dio. L'Ineffabile e i Suoi Nomi*, Acts of the First Theological Conference, Cinisello, 15-17 June 1990 (Paoline, 1991), pp. 53-71.

[4.] *Ambigua* (PG 91, 1253 D). This text has been presented and commented upon by H. URS VON BALTHASAR in his work: *Liturgie Cosmique. Maxim le Confesseur* (Théologie, 11, Paris, 1947), p. 153.

[5.] C. VON SCHÖNBORN, *L'Icône du Christ*, p. 234.

[6.] T. SPIDLIK, *art. cit.*, (n. 2), pp. 550 ss. The author refers here to the first edition of the book by L. OUSPENSKI: *Essai sur la Théologie de l'Icône dans l'Eglise Orthodoxe* (Paris, 1980). The comparison between the Russian icon of the Virgin and Child and the Madonna by Raphael is not actually and formally made, but both works are reproduced respectively on pp. 164 and 165 (illustrations n. 18 and 19).

[7.] P. FLORESKIJ, *Le Porte Regali. Saggi sull'Icona* (Adelphi, Milan, 1981 (2)), pp. 74-75. This testimony on the experience of Raphael seems to be based on a legend. Whatever the case may be, the judgment of the author on religious painting in the West from the Renaissance onwards must also be considered too severe (cf. pp. 63-64).

[8.] L. OUSPENSKI, *Théologie de l'Icône*, p. 120.

[9.] L. OUSPENSKI, *op. cit.*, p. 181.

[10.] C. VON SCHÖNBORN, *L'Icône du Christ*, pp. 145 ff.

[11.] SEE *Evangelium Vitae*, no. 43.

[12.] SEE A. M. DUBARLE, *"Les Fondements Bibliques du Titre Marial de la Nuovelle Eve,"* in RSR, 39 (1951), pp. 49-64.

[13.] ROMANUS IL MELODE, *Hymnes*, II: "2 Hymne de la Nativité," verses 6.11 (SC 110, 95-101).

[14.] Oration after the third reading (on Exodus) in the office of the Holy Sabbath: "...ut in Abrahae filios et in Israëliticam dignitatem, totius mundi transeat plenitudo." The text can be traced back to the Gelasian Sacramentary (Mohlberg, n. 435).

[15.] DE ABRAHAM (PL 14, 457, 33).

[16.] M. P. BADIENVILLE, "Roublev (Andrei)," in *Catholicisme*, XIII, 136.

[17.] L. OUSPENSKI, *La Théologie de l'Icône dans l"Eglise Orthodoxe* (Cerf., Paris, 1980), p. 144. The next page reproduces a Russian icon of the twelfth century which portrays the Incarnation.

[18.] H. SAHLIN, *Zur Typologie des Johannesevangeliums* (Uppsala, 1950), pp. 8-9. See also my work: *Marie dans le Mystère de l'Alliance (Desclée, Paris, 1988), chapter V: "Epouse* des Noces Messiniques" (pp. 183-231).

[20.] Cf. *Marie dans le Mystère de l'Alliance*, ch. VII: "La Femme Couronnée d'étoiles" (pp. 261-283).

PASCUAL PILES

The Hospital: The Temple of Suffering Humanity

1. Suffering and Life

Without entering into the philosophical and theological aspects of the question, all of us have experienced suffering of both a moral and physical character. Some of us have experienced it more than others and some have encountered it rarely and have thus been more fortunate.

Worry follows on the heels of suffering. I do not feel well; I do not know what is happening to me, but I feel bad. There thus begins an attempt to try to eliminate this suffering, to eradicate, if this is possible, its causes.

When faced with suffering we fight, we resist, we try to try to do what is best, given the possibilities we have open to us. At times we even manage to do things which we would never have thought possible. It can happen that we suffer alone but more often other people are involved in our suffering. Suffering affects and afflicts those who surround us. What happens to us has an effect on our families, our friends, and on those who act to try to improve our condition and state of mind. Each person acts according to the relationship he has with the sick person. With much due respect to the individuals involved, we can nonetheless make the observation that the person who is afflicted by illness, namely the sick person, without in any way wanting the fact, performs and plays out a distinctive role. He comes to accept the illness, adopts various attitudes and approaches in coming to terms with it and having to live with it, and responds in ways which follow certain common patterns, notwithstanding obvious points of variation between individuals. Those who treat the sick person also have a certain distinctive role to play. These professionals have their learning and skill and their ways of applying such knowledge; they also have distinctive rites which are repeated during the course of the illness. In addition, those relatives and friends who surround the sick person also have a specific role to perform, afflicted as they are by uncertainty not so much about the suffering of the person but in relation to the actual seriousness of the illness itself.

2. The Hospital as a Temple of Suffering Humanity

A temple is a holy place which the various religions of the construct to engage in worship of their gods, and a temple is specifically consecrated to this end. In the faith of the people of Israel and of the Church, obviously enough, the temple has a very evident importance. We can indeed celebrate our faith in other kinds of places but a temple is the first and primary place where we consecrate the expressions of the faith of our Christian community—believing, as we do, that it is the place where the presence of God most manifests itself. In fundamental terms the temple is the place where we celebrate the sacraments, and the most important of these sacraments is the Eucharist, the celebration of the Easter mystery of Jesus Christ.

In metaphorical terms we can perceive the hospital as the temple of suffering humanity. This is because the hospital is the place where we live out very intense moments of our lives. Sooner or later all of us find ourselves in a hospital. It is a place where many of us go because it is a part of our existence. It is a place where we consider the future from a different perspective; where different kinds of initiatives and actions designed to serve and promote life come together and act together; and where some suffer because of what is happening to them and others suffer because they take part in the suffering of their fellow men. The hospital is a place where great results are obtained from which we all draw advantage but it is also a place where we experience the powerlessness of failure when confronted by the end of a life or by the reality of death—elements which, in truth, can only be accepted.

The hospital is the place where the sick person, his family, and the professionals who look after him all take part in the pain that the patient has to endure. It is also the place, more than any other, where science places itself at the service of life and where it has thus to be characterized by great sensitivity and sensibility. It is these factors which enable us to see the hospital as a temple. It is a consecrated place, a holy place, because it speaks about pain, life and death; it draws us into a sacred world, a realm which is mysterious and final; it places us in the deepest parts of our reality. St. Paul refers to our being as the temple of the spirit (1 Co 6:19). What is sacred enters into our essence. It is in the hospital as in the temple—and bearing in mind that suffering takes place in a human being, that is to say, in the temple of the spirit—that we celebrate one of the most important liturgies of life.

3. The Easter Mystery of Human Beings Transformed into a Hospital Liturgy

We speak about the Easter mystery of Jesus Christ to express his liturgy of self-giving to humanity through his death and resurrection. When we celebrate the Eucharist, we express that mystery in relation to sacrifice and death but at the same time with full expectation of the Resurrection.

Through identification with the Easter mystery of Jesus Christ we perceive the presence of the Easter mystery in the life of individuals. We are with other people. The normal process

by which each and every person comes to achieve fulfillment is through the giving of ourselves to others and through an accompanying overcoming of selfishness. It is for this reason that we can affirm that there is an Easter mystery in the giving of our lives which can be achieved first and foremost, and both consciously or unconsciously, through the overall process of suffering, death, and resurrection.

In metaphorical terms we can say that this Easter mystery of each sick person takes place in a temple—the hospital. We can define each experience of illness as being a liturgy where we celebrate the realities of suffering, death, and resurrection, yet in existential rather than sacramental terms.

Every surgical operation involves moral suffering and physical suffering. Each and every person who enters the operating theater experiences a sleep which can be compared to the sleep of death, although, obviously enough, in this instance a reawakening is also envisaged. At the moment when the patient comes out of that sleep he experiences the feeling of suffering, that negative aspect of the Easter mystery. But he then achieves resurrection in the form of gradual recovery and his subsequent discharge from hospital. This leads him to live the meaning of his life with renewed spirit and in a new way. Similar but less obvious processes take place when other illnesses are at work.

This Easter mystery is also present in those situations when the outcome is not so favorable. The role played by suffering and death is greater when the final outcome is death. But when death is experienced in the light of faith, death itself becomes the door which leads to life. Aware as we are of this stage in our journey, and in order to ensure that it becomes a pathway to life, we must be able to pass along it with due respect and with the wish and desire to draw near to God. For this reason I invite those who are at the service of sick people to celebrate the liturgy of the Easter mystery of each sick person and to make a contribution to ensuring that the hospital is a temple which in its daily life integrates each sick person into the Easter mystery.

4. Celebrations of the Easter Mystery on a Small Scale in Hospitals which are a Temple of Suffering

This tenth international conference of the Pontifical Council for Pastoral Assistance to Health Care Workers has been held under the banner of the conclusive gospel principle of the parable of the Good Samaritan: "Go on your way, and do likewise".

Jesus identified with the Good Samaritan and invited the young man to do the same. This is an appeal which he also makes to each and every one of us and which we cannot in the least ignore.

I here suggest that we stop and reflect upon three elements which are essential to the hospital when we rightly consider it as being a temple.

4.1. The Temple Itself Must be Cared For and Looked After

Not all temples are aesthetically equal. However great care should be taken in their construction so that the community of believers can more easily be placed in contact with God. Furthermore, every kind of religious service requires its own special kind of preparation. We must ensure that our hospitals are real and authentic temples for the suffering person. We must be very attentive to the character of new buildings and to the spaces they offer; we must renew old buildings; we must keep the wards and rooms in a good and suitable condition for the patients and their relatives; we must pay a great deal of attention to the quality of their meals; and we must make sure that these temples have suitable equipment for the treatment of the patients.

It is unlikely that a person feels well when he is ill but we can ensure that he feels less ill by creating a climate which is pleasant and comfortable and by providing him with what he needs. In this way we can make sure that even when there is illness and pain a Sunday is not merely just another day and Christmas day is not just another third Wednesday of the month.

Not all places and situations have the same emotional character and resonance. When death takes place in the intensive care unit where no relatives are present, or when a baby dies within an incubator under the near and penetrating gaze of his parents (even though they are separated by the glass windows of the incubator), we are dealing with a situation which is rather different from when an elderly person dies at home surrounded by his relatives.

In the same way, the experience of somebody who feels he has died and is then cured and feels born again after a surgical operation is not the same as that of a person who wants to live but whose illness is inevitably leading him to death. However, we have to ensure that in the temple/hospital there is an experience of resurrection despite the evident experience of death which is inherent in every such process.

4.2. The Presbyters Must Serve the Community

There are many kinds of people who work in hospitals. They are divided into different sections and departments are thus not known to every patient. Doctors, nurses, administrative staff, social workers, psychologists, chaplains, members of male and female religious orders, all these categories have a role to play, whether from near at hand or from afar, in the Easter mystery of every patient.

This role must be performed with professional skill and expertise. The diagnosis and the treatment which the medical doctor prescribes is an important part of this liturgy. The same may be said of nursing care, activity of course which includes the application of this treatment, and of all those other elements in the stay of the patient in hospital which seek to render his time there pleasant and congenial.

Health care and assistance must be carried out with humanity. This is what gives the meaning of sacredness to what we have termed "celebration" within the hospital, that temple of suf-

fering humanity. Such care and assistance must be given with reference to the needs of the sick people and those who are near them. Such action must be enriched by the values of hospitality which in turn must be expressed in practical terms in service to the sick person. The achievement of humanization in this area requires an ethical project of assistance which uses the right instruments and methods to defend the rights of the patient, respect professional privacy, to inform the patient at the right moment of what he needs to know and should know, and to deal with the anxiety and worry of the patient which appears when the illness is very serious, a task, it should be observed, which is by no means easy.

Here today we find ourselves in a Christian forum of believers, a forum illuminated by the parable of the Good Samaritan. Participation in the suffering which takes place in hospital must lead the professional practitioners and protagonists of this liturgy to offer overall and integrated forms of care which deal with the physical, psychological, social and spiritual needs of the sick people who are being treated and cared for in the hospital.

In hospitals and especially in those hospitals run and administered by the Church we must employ an ecumenical vision and approach and have an organized system of pastoral care for the patients. Such pastoral care should help patients to discover the meaning of their lives and to accept the salvation offered by Christ. This should be a force for liberation whose presence is felt in silence, with affection, with support and with words, as indeed takes place in the celebration of the sacraments of penitence, the Eucharist, the anointing of the sick, baptism, and so forth. How many of us who have worked in hospitals with professional skill and expertise and with humanity have also experienced the emotion of the participation of each patient and his relatives in the Easter mystery, moved as we are by a wish to add to the richness of the reality of each patient?

How many of us have done this, taking the pastoral dimension as our point of departure and have had the happy experience of seeing many people open their hearts completely, patients who have been enriched by their form of suffering and by their acceptance of death or who have experienced the joy of being cured of their affliction? We have often shared in the pain of relatives caused by the loss of a loved one, a pain made all the more intense because the loss was unexpected or because, although the loss was expected or foreseen, it could nonetheless only be accepted with difficulty.

I give thanks to God because without causing me too much demoralization he has made me experience suffering. But I give thanks to God principally because he has given me the possibility to celebrate so many liturgies of illness, to take part in the temple of the hospital in the moral recovery of so many people whom I sought, without being overly invasive, to bring near to Jesus Christ and to the values of life.

4.3. A Meeting Place for the Community

The community which comes to the temple/hospital is made up of two great groups: the sick and their relatives on the one hand and the various kinds of professional workers and staff who are at their service on the other.

The temple of the hospital is built to serve the sick and their relatives, and it is to these people that we refer when we speak about professional skill and expertise and about humanity. Just as the bride and bridegroom promise themselves to each other at the marriage ceremony, so in the celebration of their Easter mystery the sick are in actual fact the real ministers of their sacrament. In addition, the professional staff and workers are the witnesses, even though, of course, it is they who make the whole ceremony possible.

In the community of the temple/hospital there are also the professional staff and workers. A great effort must be made to ensure that they go on seeing the hospital as a temple. There is a marked danger that our service becomes a matter of mere routine, that we will forget about the individual who is suffering, and that we will lose sight of the values which make our profession a real vocation. The many people who are aware of this are called upon to strive to revitalize the faith of ministers and professionals of the temple/hospital and thereby ensure that they go on acting in the spirit of the Good Samaritan. We must continue to be at the side of the sick person. Certainly we should not pass by on the other side of the road. In short, we must be like the Good Samaritan.

5. To Celebrate in Spirit and in Truth

In all the temples of the world the priests must conduct services in spirit and in truth. Services which are a matter of mere routine and which are drained of content are not appreciated by the gods and this is especially true of the one true God. This is clearly laid out in the Old Testament and is also stressed in the New Testament.

Jesus Christ, who proclaimed that the moment had arrived when the genuine worshippers would worship the Father in spirit and in truth (Jn 4:23), who drove the traders from the temple they had desecrated (Jn 2:16), and who told us that we do not have to worship in temples alone but that we can celebrate the Easter mystery of Jesus and thus place ourselves in contact with God wherever we like (Jn 2:21), provides us with good reasons for rendering the hospital holy and proclaiming that it is the temple of suffering humanity.

We can proclaim this because when we celebrate the Easter mystery of the suffering of the life and the death of patients and sick people, created as they are in the image and likeness of God (Gn 1:27), figures, moreover, with whom Christ identified (Mt 25:35), we are celebrating a real sacrament which by means of its redemptive value completes what is lacking in the Passion of Christ.

Conclusion

When we consider and speak about the hospital as a temple we do not do this to make sacred a space which is in itself secular. The sacredness springs from the respect due to the experience of the very many people who find themselves in a hospital, an experience made up of their living, their suffering, their dying and their resurrection.

All of those of us who are gathered here today are bound and united by a vocation to cure and to care for sick people. Today they ask more questions about why they are in hospital than about why they find themselves in temples, and because of this they have greater opportunities to open themselves to God through the experience of illness rather than through the celebration of an outer and mediocre faith.

Let us accept as Christians and as health care workers that invitation which Christ made to us, namely to do in the temple of the hospital that which the Good Samaritan did on the road to Jericho.

Brother PASCUAL PILES, O.H.
Prior General of the Hospitaller Order of St. John of God

ANTON NEUWIRTH

Secular Thought on the Mission of the Medical Doctor

1) There is no man alive who has not had direct and personal experience of suffering. Indeed, man comes crying into the world and it is with reddened eyes that he leaves it. Between these moments he has a sojourn on this planet which is by no means free of pain.

Each and every man is, so to speak, an expert on the subject of suffering, and this notwithstanding the fact that those who have replied to the question "In your opinion what is the mission of the medical doctor?" have given very different answers.

They have given answers in line with their condition of that instant: either they were ill or they were in good health, either they were old or they were young, perhaps they suffered from some pain or other, or had to endure the consequences of illness, or perhaps felt death drawing near.

In all the answers, however, there is a common denominator: "The mission of the doctor is to reduce the suffering of man." This is a reality which time has not changed at all. In the same way, the cry of the man who suffers—"I have no man" (Jn 5: 7)—has not changed either.

But what man is absent? Who is the man to whom that appeal is directed? In truth, a suffering man calls on any other man who is able to understand him and who wants to help him. He calls to someone who could draw near to him, and in truth every person who understands this appeal, this cry, is near to him. It is above all else the medical doctor who must understand him, and without paying attention to the identity of the person who calls him (cf. Lk 10: 30-37).

2) Pain and illness—such is the realm of the medical doctor. But given that both always produce pain, the physician must always dedicate himself to giving suitable attention to these phenomena. In certain circumstances, if he is not able to bear the pain, the patient can gradually fall into a state of anxiety, into a consciousness of his own predicament, into blind desperation which has only an unhappy ending.

Suffering affects the whole of the being of the patient, in all his human dimensions, in a way that is different from those forms of pain and of illness which have more or less local effects.

3) Man suffers because he lives out the real state of his health or another situation similar to this which makes the achievement of the goals of his life impossible. These goals, for every man, are the same: the achievement of his complete self-fulfillment, and in substance this is nothing else but the achievement of a state of total and lasting happiness—only this can satisfy him completely.

The doctor helps the suffering person by persuading him that suffering need not necessarily impede his happiness given that the patient is a rational and free person who is able to take decisions which are independent of time and space. Furthermore, suffering can work for, and in truth does work for, a drawing near of the patient to the goals of his life.

4) We have said that man does everything, consciously or unconsciously, to be happy. This is natural and is a part of human nature. Man, however, does not want to achieve mere happiness but absolute happiness, a happiness which for him will never end and whose intensity cannot be made greater. Happiness of this kind cannot be reached in time and space. Such a kind of happiness can have its origins only in the achievement of the Absolute—absolute Good, absolute Truth, absolute Beauty, the sum total of everything that is positive. This absolute has to be transcendental. For the believer it is God and for a Christian believer a personal God. We can see, therefore, that the orientations of men are the same and not even the goals of their lives can prevent them from becoming brothers, from being really near to each other.

5) Why, then, should man suffer, if everything within him is directed towards absolute happiness? If man does not face up to suffering but remains content with his condition and turns his back on the achievement of absolute happiness he cannot attain self-fulfillment. Man is a free and intelligent being but he has been called upon to cooperate in the achievement of his own happiness. Man has not been created in happiness but for happiness. Life has been given to man as an opportunity for happiness (cf. *Evangelium Vitae*).

This constitutes the very substance of Christian optimism and I believe that it can also be a solid basis for optimism in every other outlook on life.

And it is this "real hope" (Synod, 1985) as a solution to each and every form of suffering which the medical doctor renders accessible to his patient if he wants to help and overcome the anxiety of suffering and if he wants to prevent his patient from becoming unhappy.

A certain medical student cut his hand during a legal autopsy and the wound failed to heal. For months the diagnosis hovered between

syphilis and tuberculosis. This was at a time, it should be remembered, when there was no penicillin or antibiotics. The student wrote to his friend: “We can suffer infinitely, but this does not mean that we must be unhappy.”

6) And it is this principal idea that the doctor must place in the soul of his patient. This need, however, is profoundly influenced by the doctor's ability to know how to identify himself with his patient.

This is exactly what Jesus meant when he said that the Good Samaritan “had compassion” for a wounded Jew (Lk 10:33). His compassion was so great that he cared for his wounds, placed him on his donkey and walked with him to an inn where he paid for all his future expenses and asked the inn-keeper to look after him, thus saving him from the humiliation of acting the part of the pauper.

Jesus thus gave us an example of a complicated health service and of a system of national insurance. What is important, however, is that he emphasized that such behavior had to be the outcome and result of compassion and pity.

Because if the doctor wants to ensure that his patient faces up to suffering with optimism he must identify with that patient, he must achieve a state of full empathy with him. This involves being able to judge everything from his point of view. But being able to judge everything from another person's point of view necessarily means loving that person. Following the example of the Good Samaritan means loving his patient as himself, that is to say it means being his neighbor in the fullest sense of the term.

Does this approach to the patient not perhaps involve satisfying his every whim? On the contrary. What is the principal idea by which every patient guides his own destiny? It is that of looking for the road which leads to absolute happiness, to the fulfillment of his own personality and his own capacities. For the Christian this means looking for the road which leads to the achievement of health.

7) This concept of suffering does not in the least mean a masochistic approach to the question. It does not mean that we must be pleased at the presence of suffering and death. However every Christian

feels joyful security when he knows that the road of suffering leads to happiness and that after every suffering, and with every moment of suffering, the distant goal draws ever closer. It should be observed once again that this is an optimistic vision of life, an effective and practical program of “real hope.” And it is the task of the doctor to maintain and strengthen this optimism of “real hope,” in every kind of situation involving suffering, even when there is very serious suffering.

8) The feeling of compassion for somebody in a spirit of love also means feeling it with a spirit of humility; it means never imposing one's own opinions on the sick person. The truth should be revealed to the patient not when he has intense pain but when he is psychologically open and ready to accept the truth. In order to help him get over difficult and painful moments we must explain the meaning of his pain and suffering to him during moments of peace and when his spirit shines forth.

This involves taking the patient's own time into consideration and choosing the right moment. First and foremost, we must take advantage of that moment when the patient himself expresses interest in it of his own accord.

9) Naturally enough, certain urgent cases cannot be kept waiting and in such circumstances a small prayer should be uttered and repentance should be fostered in the soul of the patient. At times the patient with joy and of his own accord will express his agreement. At times we have to deal with an initial negative reaction but after a certain period the patient will ask for solace and the sacraments without any prompting.

10) The spirit of the Good Samaritan should be matched by help offered by the doctor in preparing the patient to take certain important decisions well ahead of time. This means that the person who foresees certain situations which are very complicated and difficult, such as those which require an important sacrifice or even the risk of dying, should consult someone—for example, a doctor or a priest—decide upon what the possible objections could be and thus prepare the ground for an acceptance of potential risks or sacrifices. This means

that we should also consider the fact that at the decisive moment the psychological pressure might be so great and intense that it will be impossible to make a decision which has not been previously thought about. In the preparation for such decisions, spiritual exercises can be of use, for example, before entering the work process, public life, politics, and so forth.

11) The last act of the Good Samaritan was the payment. "And the next day he took out two denari and gave them to the innkeeper, saying," "Take care of him; and whatever more you spend, I will repay you when I come back." This was another example of charity which demonstrates that compassion is an act of integral empathy which respects all the dimensions of man; that is to say, his biological, psychic, and spiritual character.

12) How, then, we should see the medical doctor in the light of Christian doctrine? Medicine is an interpersonal relationship between the doctor and the patient which is directed towards the maintenance, the development, and the return of health; towards making life bearable during illness; and towards the giving of help at the most important moment in life—death itself.

Given that medicine is an integral interpersonal relationship, it is not only the medical practitioner who ensures the presence of what is essential, namely the health of the patient, but it is also the patient himself who must help the doctor in the carrying out of his tasks. The health of man is priceless, and for this reason the doctor should only receive for his efforts a payment which is suitable to his personal and family needs.

The payment must never be so high as to cancel the feelings of gratitude and the spiritual link which exist between the patient and his doctor. The idea that the patient could discharge his debt to the doctor by paying him a rather high fee is a false idea which involves turning medicine into a market reality and causing its further dehumanization.

The basis of medicine is not only a high level of professional skill and competence, but also a mutual integral empathy between doctor and patient which ensures *optimism*—the "real hope" for complete and lasting happiness of the patient, even while suffering.

His Excellency
ANTON NEUWIRTH
Ambassador of the Republic of Slovakia to the Holy See

SALVINO LEONE

The Family as the Subject of Health and Illness

1. The Family as a Subject Interacting with the Sick Person

Within the complex dynamic which the time of the illness installs, the interaction between the sick person and the family certainly occupies a primary position. This relationship does not only involve reactions of a regressive kind (as a result of which the family becomes a great maternal womb in which to take refuge) or conflictual reactions which aggravate and bring to the surface pre-existing tensions which were previously covered by a layer of apparent normality. The illness should not be seen in superficial fashion as a mere irritant which interferes with a consolidated family *routine* or with a legitimate wish for a peaceful life. Each illness, especially if it is serious or in a terminal phase, involves an "adaptation" on the part of the family which undergoes inevitable change. The problems can be of seeming banality (such as having to accompany the children to school or having to leave the office early to arrive at visiting time) or of extreme complexity (such as having to take care of a patient who has suffered a number of traumas or living with a person who is mentally ill).

Equally, the mentally ill person gives rise to a number of psychological processes with the family as their specific subject: problems relating to economic or work matters, pain at seeing others suffer with oneself to blame, worry about a future which could be different and whose character should not be revealed to the family.

This picture is further worsened by a retreat on the part of the collectivity. The family which has a member who is ill can no longer lead its own normal social life. It cannot go out with friends or be with them as in the past. It cannot go to the cinema, to the theater, or on holiday. Even the church community, which should in some way be present, often ignores those families in its neighborhood which have a sick member.

At a more analytical level, and apart from the individual reactions of its components, there are various models of interaction within the family. Following the analysis of Sandrin, it is possible to identify at least four such models.[1]

The first is *linear*. In this interaction the illness involves a direct call upon the family and provokes various behavioral and emotional reactions which go from refusal to distrust or even aggression in relation to health care workers, and from regression and self-isolation to realistic trust. The linear character of the model lies in a certain directional simplicity in the psychic interaction by which the fact of illness affects the sick person and through him the family itself. The subject which is afflicted becomes in relation to the illness a "sick person" but in relation to family bonds becomes a "sick family," and this involves a sort of *trait-d'union* between family and illness. By such a mechanism the entire family becomes affected by the illness.

There is also the *circular* model where we encounter the reciprocity of the reactions of the sick person and the family which are mutually "infectious." In this reactive typology phenomena of overprotection arise on the part of the family members. The sick person (especially if a child) may dismiss his illness because he unconsciously blames the family for not being able to protect him. The model is termed circular because, differently from the above-mentioned model, it involves a greater interactive dynamism. It is as if the triad illness-sick person-family installed a kind of "vicious circle" in which each of the three subjects affects the other and involves a reaction of adaptation which, in turn, conditions the next stage of the cycle.

Another model is the *systematic* model in which the illness becomes an expression of the total crisis of the "family system." The illness becomes in this case a real and authentic threat to the family's stability (especially if such stability was previously precarious). The "lattice" structure which the various components of the family create becomes undone and can form new interconnections which can all be directed towards the sick person or, in contrary fashion, flee from him. In other terms, if the family is understood as a kind of "scaffolding" in which each element supports the other elements, it follows that a change in one of these elements involves a new mechanism by which to maintain the balance of the overall system. In this process the sick person could become excluded, and thus marginalized, because he is an element of instability.

Finally, we come to the *narrative* model. This is present first and foremost in cases of chronic illness. In such a model the illness is no longer a transitory and accidental fact but an event which profoundly effects the history of the family which thereby becomes irreversibly changed. Because of his illness, the sick person who is inserted into the family unit becomes so to speak "shared" with the health care realities which accompany him in the journey of his illness. The risk here is that precisely because of the length of time involved he becomes

psychologically if not materially "ceded" to those who are responsible for his treatment and in this way he becomes removed from the family context by external forces.

2. The Family as a Subject Interacting with the Doctor

Hitherto reference has been made to the family-sick person duality, but it is necessary to expand the horizons of analysis and involve a third subject—the medical doctor. Or more specifically—and here one uses a term which is at the present time suspended between disappearance and continuity—that figure who is still called "family doctor." In truth, and quite apart from valid and necessary forms of specialization, the family doctor continues to be an absolutely irreplaceable figure. If there is indeed a professional figure who is able to achieve an overall management of the health problems of the family (and not only of its individual members), that figure is the "family" doctor—the true and fitting "chronicler" of its health history. For this reason, it would be advisable to secure greater care and attention on the part not only of governments but also health care institutions (such as medical faculties in universities or medical associations) in order to ensure that the training of this professional figure is not only directed towards a necessary technical competence but also towards the specific requirements of a role which involves him being the protagonist of health care which is tailored to family needs.

But there is not only this area of interaction between the doctor and the family (even if it remains the most important and common point of contact). There are other moments of great delicacy and ethical involvement which see the family as a special force and, in a certain sense, an element which takes the place of the sick person.

The first is when there is a *communication of a diagnosis which predicts death*. Unfortunately there is often a tendency to hide the truth from the sick person—something which is requested by the family and supported by the doctor (who in essential terms sees himself freed from an unpleasant and emotionally stressful task). In this way castles of lies come into being, plots of silence, double meanings, taking the doctor to one side before he goes into the room of the sick person and thus depriving the patient of a right which belongs to him and creating a process of distrust in relation to the credibility of the doctor as well.

Next to this is the question of *therapeutic obstinacy*. In part this can be attributed to the doctor who is often worried that a court might declare that he has been negligent, but most of the time it is directly caused by the family members who are sincerely worried about whether everything possible is "really being done." This approach of the family is often supported by notions of a religious character which ignore or almost ignore what the Catholic Church really encourages and advocates—an evaluation based upon the principle of "proportionate treatment."[2]

One area where of necessity a family member must be called upon in the place of the patient is that of *pediatrics* (at least for the neonatal stage or early childhood). In this case as well, the right to decide always belongs to the sick person and not to others. The "guardian" role of the parents exists in ethical terms before its existence in legal terms because although the person (that is to say the child) is the titular bearer of decisional responsibility this becomes transferred to others because he is unable to exercise it.[3] The therapeutic alliance which is established between the medical doctor and the patient thus becomes a sort of three-way alliance involving the doctor, the parent and the child.

Another problem which involves the family members against their will is that of *consent for the removal of organs*. Here also emotional elements, religious cultures, and medical misinformation are present. The emotional involvement of a person who already has to deal with the difficult situation of the death of a relative (more often then not unexpected) is in itself an obstacle to a decision which should be lucid, serene, and thought through. To this is added a culture which at least in the Western World has not yet fully assimilated a mature anthropology of what the body really consists of, and at a religious level tends to identify the cult of the dead with the cult of the corpse. And to complete the picture all this is obfuscated by a great fog of news or beliefs about "dead" people who have come back to life, stolen bodies, and examples of abreathing apparatus being turned off prematurely.

Finally, with reference to the relationship between the family and health care workers, we cannot undervalue the delicate question which is inherent in the principle of *professional secrecy* and the possibilities of its being broken in response to a member of the family. One is not merely referring here to classic and traditional questions of medical ethics relating to whether a given diagnosis should or should not be revealed but to more "modern" kinds of difficulties and dilemmas, such as those involving a condition of drug-addiction or homosexuality. In this situation, as well, secrecy must be maintained because on the one hand the trust the young person places in the doctor is not betrayed and on the other because a basis is thereby laid by which the doctor can establish an ever more fruitful relationship of help with the young person.

From what has hitherto been said it is clear that there is a need for a greater awareness of the positive contribution that members of the family can make, especially if the patient has been hospitalized. In the first place the members of the family must be given suitable space and time with regard to information. It is not good enough to speak quickly when one is going down a corridor in front of the front door of the family home. The right amount of time should be given, in the right environment, with the patient's clinical record before one, and things should be done and said in a clear and straightforward fashion.

Secondly, the doctor should be sensitive to a consideration of family questions which are as important to the patient as matters of treatment and health care—weddings, the military oath of a son, or conflict and tensions between parents requiring suitable mediation. All this also amounts to "treatment" of the health of the patient in the widest sense of that term.

The doctor should also "get used" to the presence of the members of the family; indeed, he should strive to ensure that they are close to the sick person. To this end the doctor should plan suitable periods of time for visits to the hospital; make sure that the patient is not distanced from

such events as a birth or small clinical operations; and make certain that the patient is not systematically deprived of visits. With this in mind, and in order to ensure that this "nearness" becomes a reality in highly specialized institutions from regional or even national catchment areas, the problem should be tackled at a political level as well through the creation of adequate support structures (places to stay of various kinds, places to eat, and so forth) within the areas of the institutions themselves.

In conclusion, the educational sphere should not be ignored. If there is to be a real appreciation of the presence of the family, then the effort made by the doctor to go beyond the mere "two-way relationship" with the sick person which does not involve the members of the family is not enough. The members of the family themselves must become used to a new reciprocity. This is a difficult task but it is absolutely necessary, and its fruits will only be seen in the long term. An attempt must be made to tackle medical pseudo-information whereby the family "know-all" asks for information about whether an exam has or has not been carried out. In addition, initiatives must be taken to overcome the arrogance of certain people (even though they are understandably involved at an emotional level) and to guarantee greater respect for timetables and public structures. Finally, an attempt must be made to bring forth that courtesy which the medical doctor must display towards his patients.

It is clear that all this will be made the more easy in proportionate relationship to the extent to which those attitudes and approaches which are required of the patient and his relatives are identified by the doctor and the health service. At a health care-educational level attention must be paid to certain elements which directly influence the choices and orientations of the patient. First and foremost, of primary importance here is voluntary abortion for which the relative is often principally responsible—the husband who out of sense of pseudo-liberty leaves the woman alone with her decision or the mother-in-law who does not want to bear the burden of other children.

If one really wants a family, that is to say a community of love and not a mere social aggregation, to "live" the illness of one of its members and to be helped in doing this by the health care workers, then everybody at all levels should take upon themselves a greater degree of participation and the implications that this involves with regard to a more direct influence on the health/illness dynamics which one of the members of the family may come to experience.

3. The Family as a Subject Causing Illness

At times it happens that in the complex set of causes which give rise to an illness the family comes to acquire

a true and authentic causative role of which it is more or less aware. This is true above all else in the case of *genetic illness* which with the common denomination "hereditary" makes explicit reference to the family. A transposition from the level of simple biological reality to that of existential difficulties takes place through an unconscious identification of "causality" with "responsibility." This phenomenon is similar to what happens when a partner blames himself for being sterile. But it can acquire different and more intense connotations because of the "damage" caused to the child. It is very significant, for example, that there is a variation in the response to the presence of a Down syndrome child on the part of the parents according to whether the anomaly is caused by an existing genetic anomaly in one of the two parents or by a spontaneous mutation. In this last case the parent feels to some extent released from his (albeit involuntary) responsibility.

One phenomenon which is on the increase and causing great worry is *anorexia* (and its counterpart bulimia), and this can also involve a causative influence on the part of the family. In this as in other pathologies which have a psychological origin in reactions to family contexts, great care and prudence are required. An inappropriate release of information bears the risk of placing excessive blame on the parent and thus creating discord which will in turn render treatment of the pathology even more difficult. The most important fact here in relation to the family/health relationship is that in this—as indeed in other similar cases—it is not possible to treat the sick person without a parallel treatment of his family.

Similar considerations (which are by no means analogous) can be made for *drug addiction*. Indeed, the traditional paradigm which detected in various forms of family "maladjustment" one of those component elements of the genesis of such a condition, is slowly changing into a new model where the drug-addict is perfectly inserted into the family unit, has a regular job, and so forth. This is a model which in various ways tends to be like those which deal with other forms of addiction involving such agents as tobacco or alcohol. But in such cases the role of the family in overcoming the dependency is no less important (even though such a role may be more difficult). In order to achieve success, it is probably the case that in the future one will not aim so much at a "healing" of the family unit whose "pathology" has been a causal factor behind the addiction, but at requiring a family which is already "healthy" to transmit values which act as elements of true and effective prevention with greater force and credibility.

Finally, the members of the family should also embrace the absolute and inescapable duty not to *cause each other mutual harm*. Laws which prohibit smoking in public places are very welcome but at a health level the problem of smoking in private places is even more serious, and by private places one here refers to the family context. What should be done about this

particular problem?

Furthermore, it is within the family that violence to young people and other forms of domestic violence are still practiced today. If such shameful violence does not have a permanent effect on physical health it leaves very deep scars on psychological health.

But even without reaching such excesses, the thousand other forms of more or less manifest conflict which take place every day within the walls of the family home should not be ignored. Such things by that mysterious and still largely unknown route between the body and the mind are at the base of an ever growing number of *psychsomatic pathologies*. Behind an ulcer or gastritis, an attack of asthma or a skin complaint, we often find a component which is in some way to be attributed to the family, if not indeed to a set of causes rooted in the family.

4. The Family as a Subject Promoting Health

From what has hitherto been observed, a clear dialectic emerges between the family and illness. It is intricate and many-sided but overall its essential features are more than clear. The question of the relationship between the family and health, which is the positive side of the coin, is rather more elusive. In what terms is the family involved in the "health system" of the individual and society, in its stewardship, its maintenance and its promotion?

By now we well know the World Health Organization's definition of health as "full psychological, physical and social health." We are rather less aware of the objections which have been raised to this definition which are chiefly centered upon an absence of a dynamic perspective, a lack of involvement of the spiritual dimension, and in a certain individual absoluteness which involves the risk that the health of other people will be abused. With these limits in mind (and thus the horizon of their being overcome as well) we can without doubt say that the present-day understanding of health fully covers the meaning of the Latin *salus* which was not mere *sanitas*—as indeed a paper presented to this international conference has rightly pointed out.

For precisely this reason the family cannot escape such a perspective—indeed it is brought into action precisely by such a perspective. The problem it seems to me must be tackled with reference to certain guidelines which are of primary importance.

The first guideline concerns the duty of the family to *look after its own health*. It is certainly true that most responsibility here is in the hands of the parents but other members of the family in various ways are involved as well. One important sphere is that of a correct upbringing with regard to diet—one of the best ways of inhibiting the

present-day increase in food related allergies and contributing to the prevention of future pathologies such as heart disease or cancer of the gastroenteric tract. One other important area is that of domestic accidents (above all else affecting children) which are still responsible for a large number of maladies caused by lack of care. Yet another area is that of "healthy psychological attitudes" such as the cultivation of feelings of mutual benevolence, the development of a critical approach to the invasion perpetrated by television, and inculcating mutual listening at times of common interaction such as meals.

A second guideline is that of *looking after one's own health in the light of its being something which does not belong to us*. This is perhaps an approach which is more difficult to understand. Indeed, the widespread "principle of autonomy" or the myth of "one's own fulfillment" obscure the fact that certain things which we consider "ours" do not in fact belong to us—such as, for example, health. The duty we have of stewarding it thus becomes a form and expression of love towards our family. In such an attitude we encounter that "culture of giving" which is today so often invoked in relation to the donation of organs.

5. An Evangelical Perspective

In tackling the difficulties and dilemmas of the family relatives of the sick person a perspective of a certain interest can, I believe, be found in certain episodes which the Gospels have left us. When examining the healings effected by Jesus normally emphasis is placed upon the miraculous episode and the contextual elements which surround the miracle are neglected. The family relatives form a part of the context and they are fully involved in the episode which we are told about. The attention which Jesus pays to the sick person thus reveals itself to be "integral" attention paid to the world of that sick person. Furthermore, he seems in a certain sense to "redeem" certain presumed devaluations of family reality, as for example happens with the strange answer in the temple, the "repudiation" of blood ties in favor of those of the spirit, the invitation to let the dead bury the dead, "hate" for one's family as a pre-condition to following him, and so forth.

In many of the accounts of miracles regarding the body a family member is present who always plays an important part in the dynamics of the fact.

In the three miracles of resurrection—Lazarus (*Jn* 11:1-44), the son of the widow of Naim (*Lk* 7:11-17), the daughter of Jairus (*Mt* 9:23-26; *Mk* 5:35-43; *Lk* 8:49-56)—it is clear that because dead people were involved the request for help could only come from the relatives. Yet the Gospels make clear that Jesus shared deeply in their human travail. This was true not only in the case of Lazarus (with whose family he had ties of friendship) but also for those who were "unknown" to him—what led to the resurrection of the boy from Naim

was the pity that Jesus felt for his mother to whom he restores him ("and he gave him to his mother" *Lk* 7:15). In the case of the daughter of Jairus what is remarkable is the choice of those who should be present. When everybody had been left outside, Jesus allowed in only Peter, James, John and *the parents*. After the miracle, and in order to demonstrate the fullness of corporeal reality, Jesus invited them to "give her something to eat"—this also is a typically familial element.

In addition to the case of the daughter of Jairus there are other healings which are directly "requested" by parents—the son of the nobleman (*Jn* 4:46); the epileptic youth (17, 14, 27); *Mk* 9:14-29; *Lk* 9:37-43); the woman from Cana (*Mt* 15:21-28; *Lk* 7:24-30) where praise for faith must not make us forget the mother's courage displayed by this woman, who found herself in a hostile environment and replies even with a certain humor to the words of Jesus. And this is not to include all those times that "they bring him" sick people to be healed where it is very probable that within such groups were to be found the sick person's family relatives.

At times it is Jesus himself who notices a relative who is sick, as happens in the case of Peter's mother-in-law (*Mt* 8:14-15; *Mk* 1:29-31; 4:31-37). At times perhaps their absence also contributes to the genesis of the miracle, as in the case of the paralyzed man at Bethseda who declares that he has "no one to let me down into the pool" (*Jn* 5:2-18).

There are also less idyllic situations such as that of the parents of the man blind from birth (*Jn* 9:1-41), who out of a fear of the Jews refuse to point out the man who has worked the miracle and "place such a burden" on their son.

If it is true, as the Pope often says, that the future of humanity depends on the family, and if it is true that the health/illness tandem involves each human being in profound fashion, then to the family dimension of such an existential experience in the future one cannot but give, and in a far greater measure more than today, all the attention which such a dimension deserves.

Professor SALVINO LEONE
Professor of Bioethics
at the University of Palermo
and at the Theological Faculty of Sicily

Notes

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[2.] Cf Congregazione per la Dottrina della Fede, *Dichiarazione sull'Eutanasia,* 26 June 1980.

[3.] M. CUYAS, "Il Medico e il Minore," *KOS*, V, 38, 20.

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JOHANNES BONELLI

The Technological Challenge of Modern Medicine

Over recent decades medicine has achieved notable advances in nearly all of its spheres of action. This has been largely the work of a technological revolution within medicine and has undoubtedly amounted to a very great good for the whole of humanity. However, it should be stressed that this development has involved a domination of medicine by technology. This domination, in turn, has created a certain tension with the traditional Hippocratic vision and has cast a spell which both medical doctors and patients have resisted with difficulty.

This dilemma, which we might deem dialectical in character – between praise for technology and Hippocratic ethics, seems to me to constitute the real and authentic challenge of technological medicine at the present time. Ever since the times of Descartes we have observed an explicit goal of the natural sciences: the wish on the part of men to become the lords and masters of nature through the employment of technology.[1] Thus the World Health Organization has declared—and not without a certain arrogance—that one of the goals of medicine is the complete and systematic elimination of every form of illness (and even the overcoming of death) for all men.

It is certainly true that one cannot deny that contemporary medicine remains miles distant from the achievement of this goal, and this notwithstanding the great advances which have been made in the medical sphere. Indeed, contemporary medicine finds itself in a rather confused state in the face of a number of questions and difficulties which have arisen and which seem without a solution. The situation is rather like that of the sorcerer's apprentice who is faced with the spirits he has conjured up with his spells.

Some examples can be given of this:

The technology of in vitro fertilization has meant that an innumerable number of human embryos—and thus human beings—end up in a state of being frozen, waiting, as it were, for their destiny. This really means their destruction because in actual fact there is no need for them. To put it in simple terms: humans are created by artificial means only to be destroyed because there are too many of them.

On the other hand, modern medicine has led to a notable raising of the average life-span of people without, however, a life of good health being guaranteed to the elderly. On the contrary, an increase in life-span is usually obtained at the price of a spiritual and physical ill-being which individuals find difficult to bear. Thus it is that the invitation to euthanasia gains ever greater force. It is for these reasons that John Paul II in his encyclical *Evangelium Vitae* refers to a culture of death which pervades our century and to which—as I will seek to make clear—technological medicine has made a by no means irrelevant contribution.

In such a situation it is now possible to speak with truth of a technological challenge within medicine. This challenge involves a very special urgency. There are, it seems to me, three aspects to this challenge:

1) going beyond an image of the world which is mechanistically reductive;

2) distancing ourselves from the opinion—which is today very common—that each and every expression of medical technology from a purely moral point of view is neither good nor bad but receives its moral relevance according to the intentions and circumstances with which, and within which, that technology is used.

3) in recognizing (to conclude) that perhaps today's medicine raises hopes in man which in actual fact it is absolutely unable to meet. Reference has already been made to the declaration of the World Health Organization and its utopian goals. A reflection is necessary in relation to the image that the medical doctor has of himself and of his profession. The idea that he has power over life and that he is the lord of life and death should be abandoned.

In the following paragraphs these three challenges will be examined in detail.

1. Naturalism and Teleology

As has already been observed, modern natural science has become devoted to unconditional naturalism. This is rooted in the assumption that no rationally established order of the creation is to be found in this world. On the contrary, it is argued that it is man himself who determines the ends of nature. This illusion of a subjectivity, this unlimited freedom to determine things on the part of man has led not only to those environmental injuries which give rise to so much complaint nowadays, but also to an extreme lack of understanding within medicine in relation to matters involving the requirements of Hippocratic ethics. Abortion, prenatal and eugenic diagnoses, sterilization, contraception, research carried out on embryos, the transplanting of embryo tissues from aborted embryos, and all the rest, are, for example, absolutely incompatible with the *Hippocratic Oath*. Yet all over the world these are carried out *routinely* and without the least scruple.

The metaphysics of creation according to both the Hippocratic and

the Christian points of view, in contrary fashion, recognize that there is a rationally established creative order in the things of the creation and that man must be respected because he has been constituted as a creature of God.[2] According to ancient Hippocratic teaching, man is not the master but the steward and defender of life. For this reason, he must respect certain barriers which must not be crossed and which have been allocated by the Creator to created reality and—in special fashion—to the human body. The things of the creation have their own order which is rooted in their own nature and their own truth. This order must also be reflected, in the Hippocratic view, in the actions of the medical doctor at the very moment that he places his art, or rather his technology, at the service of this order. For this reason, every form of arbitrary manipulation carried out on the human body which is not directed at a therapeutic treatment of the health of the patient is an abuse of the art of medicine. We may give as examples of this both sterilization, which is now widely spread at a planetary level, and more in general practices which we may deem "anti-procreative."

Indeed, those who see reality and man himself as mere products of chance along the lines of an indiscriminate evolutionism, and deny God, are unable to perceive in the creation any pre-established usefulness or any previously given immanent meaning. This meaning is established, so to speak, by man himself, and for this reason questions about whether his actions are justified or not turn out to be practically useless. According to this line of thought, the medical doctor in his actions and approach, in similar fashion, is not linked to the goal of care aimed at healing. Such a concept of medical technology must of course be fought given that it opens the door to a state of affairs where not human rights but the rights of the strongest end up by being placed at the base of medical ethics, as indeed is borne out in systematic fashion by the practice of abortion, which has by now become worldwide.

To recapitulate, the first and essential challenge which confronts technological medicine today lies in the discovery and recognition of an immanent meaning in the creation which is already present and to which every form of technology must be subordinated. We should above all else be aware of the dignity of man, and recognize that he is both a physical and a spiritual being. This is of the utmost importance, notwithstanding the great attraction of what can be actually achieved by technological means. The patient is not a machine which functions well or not so well. He is not the casual outcome of evolution. He is the living image and creature of God, and must be treated by the medical doctor in a way which conforms to this dignity, above all.

2. Technological Medicine Is Not Always Indifferent

The second challenge is essentially a continuation of the first. Until a few years ago it was perhaps possible to be of the opinion that medical technology is not as such good or bad and that its moral relevance is to be found solely in the motives of those who are connected with it.

But John Paul II has clearly demonstrated in his encyclical *Veritatis Splendor* that there are also actions which by the mere fact that by their very nature they cannot be referred to God constitute a moral wrong, and this quite independently of the intentions involved or a general balance of effects which might be drawn up.[3] Indeed, certain modern medical techniques involve such actions from the very start which are in themselves wrong. We may give as examples of this, once again, such phenomena as in vitro fertilization, the cloning of embryos, and contraceptive methods. From a Christian point of view such things must be abandoned from the very beginning because they already express within themselves a morally erroneous form of behavior. The person who completely denies that there is a natural order in the creation or that this has been placed there by God will never be able to accept this challenge of modern medicine—that is, he will not embrace the placing of limits on himself and what he does by abandoning what could be achieved in theoretical terms.

3. The Absolutizing of Technological Medicine

The third challenge of technological medicine lies in its constant tendency to adopt an attitude of presumption and overvaluation in rela-

tion to itself. A medical science which places such trust in its own power over nature to such an extent as to dare to guarantee not only health but even dominion over death for everybody leads to something which should not surprise us—the fact that the citizens of this society call unreservedly for the right to health. A patient recently addressed the following words to his own doctor: "Connect me to a machine which will enable me to eat better and tolerate smoking with greater ease." The limits to these utopias will very soon, however, become evident, and we should not be surprised if dissatisfaction increases and if some patients lose hope when faced with an incurable illness and go on to seek to put an end to their own existence with the assistance of their medical doctor.

From ancient times medicine has seen its task as being not only the unconditional healing of the patient but also the relieving of suffering and the comforting of those who are ill. Hippocrates saw illness not only as a physical-chemical event brought about by specific causes but also as a disturbance of the essence of man in his totality.

A categorical use of all instruments and means which are technologically possible without reference to their relativity or partiality or even without taking the will and the needs of the patient into account would mean reducing medical action to a mere technical reality. It would, however, be too reductive to see the therapeutic purpose of medicine as being exclusively a matter of dominating biological laws. This is because human medicine is not a superior form of animal medicine. It is, instead, medicine for man—he who always remains our neighbor, as indeed is well expressed in the parable of the good Samaritan. Medical doctors and health care workers, therefore, cannot merely approach and treat the illness alone—they must always have the whole sick man before them. The person who employs a mere technological approach in the medical sphere no longer treats man as a subject but does so with the individual as an object. Thus the advances in the realm of technology must not escape the control of doctors and health care workers. On the contrary, these latter—and in a very specific fashion—are called upon to defend the humanity of man against every attempt at domination of him and his dignity by technology.

Here, however, we need something which goes beyond the usual needs of a profession and its daily routines. Thus it is that in historical terms service to the sick person has always been seen primarily and principally as a vocation, as a mission which pervades our whole existence and our whole humanity. The well-being of the sick person must always and everywhere represent the principal and supreme guiding motive of our action. Help towards the sick person must necessarily go beyond merely performing a duty, a question of doing something with reference to convention alone. Here we are dealing with helping someone, even when we must endure sacrifices, risks or annoyance. Indeed, this is the case even when such things are taken for granted by the patient or when we are faced with mere misunderstanding, injustice, or even insolence and lack of gratitude.

To ensure that we meet such a requirement we need heroism, a big heart and a special development of our feelings. The question of whether a particular treatment should or should not be applied to a patient is too complicated to be left to mere technological considerations. Of essential importance to such a question are other factors: the personality of the patient, his actual conditions of life in this world, his scale of values, his psychic make-up, his environment, his kinship ties, and all the rest. To such matters and dimensions, however, one can only respond with the heart and with altruism, and with the shared consent of all those who are involved in caring for and treating the sick person.

In order to avoid misunderstandings about what has already been said, I would like to express some warnings about certain tendencies which place the heart and the intellect in opposition to one another, see concern for the patient as the antithesis of technological efficiency and competence, and set an all-embracing form of medicine against medicine based on the conventions of training. There is a very great danger that today the pendulum will swing to the other side and that humanity will become confused with fanatical and utopian zeal and with sentimentality.[4] The consequences of such a development would certainly be negative. Authentic humanity would not exclude professional competence and technological

knowledge but would constitute its basic building block. A personalistic form of medicine which took the form of mere sharing and self-identification would not be an adequate counterweight to the danger of planned manipulation and it would not promote an accurate appreciation of the value and the impact of human reason. The overall argument presented in this paper is directed towards a universal way of seeing true humanity.

In conclusion, a number of observations should be made. When faced with the advance of medicine—a development which is connected first and foremost to forms of technology which exercise increasing dominion over man—doctors and health care workers cannot escape questions regarding the meaning of what they do. All the ethical difficulties and dilemmas of the profession which are constantly arising in today's practice of medicine—both as regards decisions about diagnosis and actual treatment and in relation to the kind of relationship which should be established with the patient (and all the rest)—in the final analysis reflect contemporary man's questions about the meaning of suffering and more generally the meaning of life and being.

Upon such questions depend, in essential terms, the answers to a very practical situation.

The great differences with the other professional worlds are to be found in the fact that both doctors and health care workers cannot retreat into forms of activity and behavior which are merely professional, into a mere performance of duty in a way which is emptied of reference to the deep meaning of human essence in its entirety, without thereby rendering such actions automatically inhuman. We are called upon always to be competent specialists and at the same time men—that is, we should always be near to our patients. Our activity is constantly accompanied by the risk that we injure human dignity.

For this reason, and without abandoning the scientific dimension of medicine and its practice, the physician and his helpers must rediscover the first and last essential point of reference—man as a person who quite beyond the natural sciences has a history and a future; a free being bearing a meaning and a purpose, the image of God, called to love and to devotion, the crowning element of the creation. We could not approach such a version of man with a mere technological inheritance and a narrow knowledge of individual physical functions and disturbances. To carry out our task—which is certainly much more than something which has a mere therapeutic content—we need a restoration of the general humanistic formation and training of the medical doctor and health care workers in order to achieve an anthropological and philosophical culture, a culture of the heart and of love which can only be achieved in the sense of the good Samaritan. Only in this way, it seems to me, can we meet the challenges to which technological medicine now gives rise.

Professor JOHANNES BONELLI
President of the Institute of Medicine, Anthropology, and Bioethics in Vienna, Austria

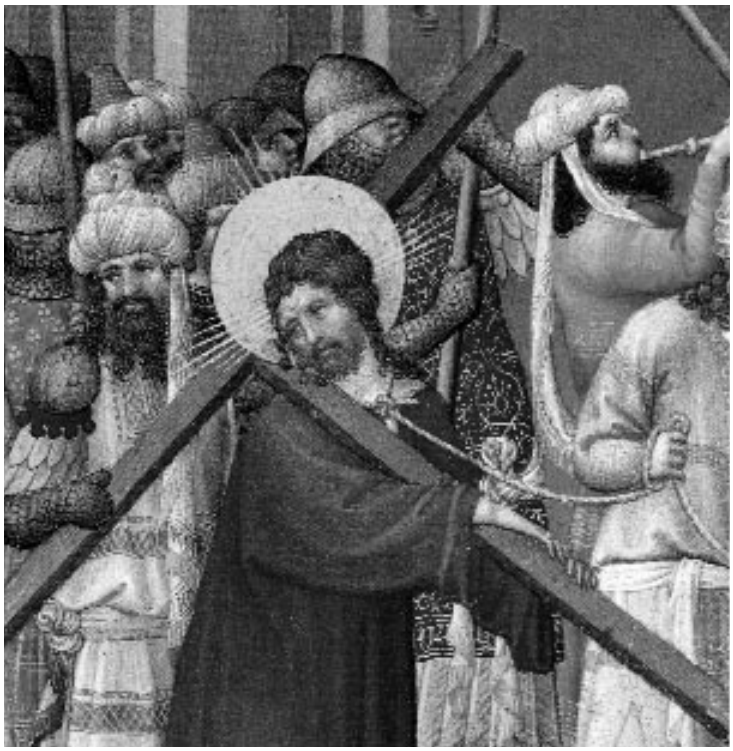
Notes

[1.] E. PRAT, *"Naturalismus und Menschliche Fortpflanzung"* (Naturalism and Human Reproduction), in IMAGO HOMINIS, Vol. II, no. 2, pp. 121 ff.

[2.] See *C. Lichtenthaeler, Der Eid des Hippokrtaes, Ursprung und Bedeutung* (The Hippocratic Oath: Origins and Meaning), (Deutscher Arzteverlag, Cologne, 1984), pp. 189 ff.

[3.] See *Veritatis Splendor*, 80.

[4.] See R.BUTTIGLIONE, "Die Achtung des Unschuldigen Lebens, ein Prufstein Unserer Kultur" (Respect for Innocent Life: a Test for Our Culture), in *Der Status des Embryos* (The Status of the Embryo), Verlag Fassbaender (IMABE Hrsg.), 1989.



ERWIN ODENBACH

Respect for the Patient's Privacy

"Respect for the Patient's Privacy" / "Le respect de l'intimité du patient" is the subject which you proposed in your invitation, which was an honor for me and for which I thank you most sincerely. Important statements can be made on this subject in just a few words. Upon giving the matter a little thought, particularly when remembering one's own experiences as a patient, many thoughts come to mind, especially if one is a doctor oneself, some of which may appear banal.

I would like to break down my presentation into the following sections.

1. The importance of the personality of the patient.
2. The importance of the illness or injury.
3. The importance of spatial factors (in the doctor's office or hospitals, occasionally even outdoors).
4. The importance of the treating persons, that is to say, of the staff in doctors' offices, the out-patient department or hospital, and the ethical rules and duties of the doctor.
5. The importance of faith and ministry.
6. What threats and limitations to privacy are there, and what must be done in order to preserve and respect it?

Allow me not to go into detail on the definition of the English, or particularly the American, term "*privacy*" and the French term "*l'intimité*". It is worth noting that the German language only permits an exact translation in the sense of "private sector" or "private sphere," at best. Esactly what "privacy" is, and what it covers in detail, is most easily realized when it is infringed upon or when it is absent, as in totalitarian systems.

1. The Importance of the Personality of the Patient

Is there any need here to emphasize the unity of the body, mind and spirit of a human being and his or her—immortal—soul? However, it is all too often forgotten in our everyday lives. The indestructible dignity of the human person is the prerequisite for true freedom and for these thoughts I am going to present to you. Respect for the patient's privacy is a right of the patient.

The problems involved in realizing this right are to be dealt with here.

Attention must be paid to the dependence of the personality on various factors.

a) Age.

b) Differentiation and intellect. Is the patient religious?

c) His sociableness (is he extroverted, introverted?), his openness.

d) His inclination and interests (Does he like to read? Does he listen to music?).

e) The social background, such as family, friends, and visitors, but also the absence of visitors.

f) The ethnic situation. This can differ greatly just within a country, and most certainly in the case of distant peoples with occasionally large families.

2. The Importance of the Illness or Injury

Is an acute illness or a chronic illness involved? Is it

a) A broken bone? An accident?

b) Cancer?

c) An infection (possibly requiring isolation)?

d) A handicap?

e) An interfering functional impairment (faecal incontinence, incontinence of urine)? Is the patient capable of walking? Permanently confined to bed? Unable to speak?

f) Is he on an intensive-care ward?

g) Is he receiving artificial respiration?

h) Is he unconscious?

i) Is he mentally impaired, mentally ill? Confused?

Many things need to be seen to if someone is ill or in a life-threatening condition—not only financial disputes and inheritances. Some matters have to be discussed with parents, between spouses, with children or with friends, interpersonal tensions may perhaps need to be resolved.

The relationship with God, the dependance on medical care and nursing aid are of importance.

These considerations bring us to the spatial prerequisites.

3. The Importance of Spatial Factors (in Doctors' Offices or Hospitals, Occasionally Even Outdoors) for Privacy

Privacy is very much dependent on spatial factors (single room, multiple-bed room, open ward, intensive-care ward)! The possibility for receiving visitors (family, friends), the visiting times, recreation rooms and a cafeteria play just as much of a role as consideration for the patient's illness (is it a malignant, protracted disease, a broken leg or an operation not presenting a threat to life!). The country, the continent, the climate, the financial resources, and the illnesses particularly common locally

have an effect on the architectural design. Single rooms alone can play a major role. In large open wards (such as still exist in some very old hospitals), compromises have been achieved by installing "booths" with their own service connections (telephone, radio, etc.), which allow a certain degree of privacy. However, large, open wards without partitions leave hardly any room for privacy to be respected.

In contrast, single rooms are sometimes anything but desirable for young people—for instance, with a broken leg or during a short recuperation phase after a minor operation. These patients would like to play cards, chat among themselves, or watch football on television. For other, highly differentiated, intellectual people, it is largely a question of the nature of the fellow patient in a double room, or the other patients in a room with three or more beds: quiet or talkative, constantly listening to the radio. Aesthetic problems and even revulsion can occur in cases of illness. If necessary, it is the task of the staff to take such factors into account when assigning patients to beds and rooms.

In a doctor's office or an out-patient department—in the waiting room, for example—questions asked in the presence of other patients, or even other staff members in the room, are often extremely tactless. "How old are you?" "What does your husband do?" "Who are you insured with?" "Will you be paying privately?" None of that is anyone else's business! And certainly not questions about the medical history!

A brief note on single rooms. During several visits to America. I noticed on various occasions that single rooms in exemplary hospitals were sometimes fitted with two doors: a normal door closing the whole frame and a second "half-door", so to speak, which vaguely reminded me of the doors in stables, although that is in no way meant negatively. I was told that a lot of patients did not like to have the normal door shut, precisely so that they could keep more in touch with their surroundings.

Quite often, the patients were standing at this half-door, looking down the corridor, so that their head and feet could be seen from the corridor. This is one way of giving patients a great degree of freedom, provided that they are the ones who decide when and how they want to have their rooms closed or open without giving everybody a full view.

The options for providing accommodation of this kind are to a major extent dependent on the available finances. Thought must be given to the helplessness of the patients when allocating the necessary funds.

An increasing amount of home care, now being provided less and less by the family and more by competent, mobile professionals, occasionally already supported by the modern methods of telemedicine—which permits constant communication between patient and care center—would make many things easier, such as the patient's being able to stay in his or her familiar surroundings. However, new problems of confidentially also arise.

This certainly also applies to the possibilities offered by new methods of data transmission and storage which, while allowing extensive information to be made available rapidly, will cause a few problems yet as regards the accessing of such data by third parties.

The *seal of confession*, maintained, guarded, and defended by the church and the individual priests for centuries, is time-proven evidence of respect for the dignity of the individual and thus for his or her privacy.

However, privacy is not just a matter of comfort and the tendency towards creating a hotel atmosphere in a hospital. It also has an essential bearing on
- the psyche,
- the spirit and thoughts, and thus on the soul.

And this particularly in an era when many people seem unable, or hardly able, to bear silence any more. Closely linked to this is the *problem* of the room, but also of the chapel and support through ministry. Although this says nothing against the fact that some patients enjoy a change and entertainment.

Thousands of people around the world are constantly getting involved in accidents. Even when receiving first-aid and emergency medical treatment—generally on the roadside—their right to privacy must not be forgotten. The reports broadcast on television—often showing the full brutality of the scene—are a flagrant violation of human dignity. The same goes for nosy onlookers who are incapable of providing competent assistance and merely get in the way.

4. The importance of the treating persons, that is to say, of the staff in the doctor's practices, out-patient department or hospital, and the ethical rules and duties of the doctor

The staff in surgeries and hospitals are of great importance as regards guaranteeing the maximum possible privacy. They bear a major responsibility in this context, but one which is unfortunately often forgotten. In addition to their professional competence, the human touch of the staff is the most important factor. The tactfulness they are taught when studying medicine or training as nurses is a task that also needs to be fulfilled throughout life. The human factor in the staff has priority for the well-being of the patient, above the economic situation of the country and the community. Privacy cannot by guaranteed *solely* by means of paragraphs, and also not *solely* by offering good premises and rooms. It is the task of the staff to take numerous factors into account when assigning patients to beds. I have already emphasized this point, as well as the avoidance of tactless questions in the presence of third parties.

However, at this point, I would like to quote the old master among German internal specialists, K. D. Bock: "Anyone who looks after seriously or fatally ill patients, day after day for hours on end, cannot beat it without a certain degree of internal 'shielding,' the partial suppression of compassion and feelings. The more pronounced his or her spontaneous empathy and ability to share suffering, the less able he or she will be able to bear it. It is impossible to constantly put yourself into the wretched human situation lying in front of you and still act rationally... ."

This makes it easier to comprehend—with some understanding for various shortcomings in everyday practice and routine—that the situation of the Good Samaritan is often forgotten. This may perhaps be excusable. However, things that "we" may consider *everyday routine are exceptional situations* for the patients, with their worries, suffering, and oversensitivity, and thus inexcusable from their point of view. Therefore, we must make a constant effort to change this so-called routine behavior, but without overdoing things by displaying overattentiveness, which some patients may possibly find too familiar. The education work done during basic medical education is of great importance. The appropriate specialization and continuing medical education is also essential during a long professional life, as is the setting of an example—an aspect where leading personalities bear particular responsibility. Team discussions promote an understanding for the individuality of each patient and cast light on errors and omissions.

The following new code is also of great importance for the privacy of the patient. The 47th WMA General Assembly in Bali, Indonesia, passed very recently the following declaration on the rights of the patient on September 7, 1995.

The declaration is far more comprehensive than the preceding document on the same subject, which was adopted in Lisbon in 1981. It consists of a preamble and principles concerning the following areas.

1. Right to medical care of good quality
2. Right to freedom of choice
3. Right to self-determination
4. The unconscious patient
5. The legally incompetent patient
6. Procedures against the patient's will
7. Right to information
8. Right to confidentiality
9. Right to health education
10. Right to dignity
11. Right to religious assistance

In all of the 11 areas named, the focus is on the protection of the patient, his/her personality and his/her own decision. The exact wording under "Right to dignity" is as follows:

a. The patient's dignity and right to privacy shall be respected at all times in medical care and teaching, as shall his/her culture and values.

b. The patient is entitled to relief of his/her suffering according to the current state of knowledge.

c. The patient is entitled to humane terminal care and to be provided with all available assistance in making dying as dignified and comfortable as possible.

Furthermore, Item 11, "Right to religious assistance," reads:

"The patient has the right to receive or decline spiritual and moral comfort, including the help of a minister of his/her chosen religion."

The draft of this substantially expanded new version of the rights of the patient was submitted by the Finnish Medical Association. The version now adopted by the world's doctors should be appropriately publicized and enforced by the medical organizations in the countries of the world, although it should be noted in

this context that these rights of the patient are in no way only rights vis-à-vis doctors and other health professionals. Rather, the preamble states that: “Physicians and other persons or bodies involved in the provision of health care have a joint responsibility to recognize and uphold these rights. Whenever legislation, government action, or any other administration or institution denies patients these rights, physicians should pursue appropriate means to ensure or restore them.”

Allow me to emphasize that Item 10, “Right to dignity,” which I just quoted, expressly mentions the term “*privacy,*” which “shall be respected at all times in medical care and teaching, as shall his/her culture and values.” The task now will be to ensure that this decision concerning the patient’s rights does not simply remain a declaration, but becomes a *behavioral code that is a matter of course* for all people working with patients and for those bearing responsibility. It will hardly be possible to achieve this everywhere overnight, but it is our duty to make repeated efforts to reach this goal.

The *Hippocratic Oath* itself already states: “...and to disciples bound by a stipulation and oath according to the law of medicine, but to none other. I will follow that system of regimen which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner, I will not give to a woman a pessary to produce abortion.” It goes on to say: “Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.”

When the World Medical Association was founded in 1947, it adopted the so-called “Declaration of Geneva” as a new version of the Hippocratic Oath.

This declaration was revised and supplemented in the years that followed. The World Medical Association’s International Code of Medical Ethics states, among other duties of physicians to the sick: “A physician shall always bear in mind the obligation of preserving human life.” “A physician shall owe his patients complete lovalty and all the resources of his science.”

Furthermore: “A physician shall preserve absolute confidentially on all he knows about his patient even after the patient has died.”

The “Declaration of Geneva” of September 1948 additionally reads:

"The health of my patient will be my first consideration.” “I will respect the secrets which are confided in me, even after the patient has died.” “I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient.” “I will maintain the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge in ways contrary to the laws of humanity.” The rights of the patient have been dealt with in other declarations of the World Medical Association relating to individual subjects, although these are too numerous for all be mentioned here. There can be no doubt that the thoughtlessness of people working with patients is only rarely intentional, but it does lead to situations where the patient feels that his/her privacy has been violated.

5. The importance of faith and ministry

"The person is the center of all things", is the guilding principle of all our medical activities.

However, as a final refuge when ill or troubled, God is the center of all things for many patients, even if they have not prayed and have suppressed all thoughts of God in years of religious indifference. Thus, religion acquires a special importance in sickness, not only when death is close at hand. It must be possible to talk to a minister, confess, and receive Holy Communion. A church or chapel, which should be open at all times, a minister and a sanctuary on the premises are important for practicing religion, receiving Holy Communion, confession and the Holy Mass. Possibilities for driving patients to Holy Mass (in the case of lengthy illnesses or inability to walk) should already be taken into account when planning a hospital or during subsequent conversion.

There are unmistakeable signs of growing confrontation and a trend away from the “I” to the “we” (also in the church—in the style of prayer, in devotions; the development from the individual confession to the widely propagated, anonymous penitential devotions is also particularly important). The sick person, the patient, also wants the opportunity to be undisturbed and alone when communicating with God. In view of the increasing emphasis on the “group,” the “community,” and “society,” the question arises as to what happens to the individual, the personality, privacy? The word failure, “guilt” (and thus also sin) is a concept associated with an individual person. The relationship between God and man, between you and me, between father and son, between creator and creation is essential, particularly in times of illness. The *seal of confession*, maintained, guarded and defended by the church and the individual priests for centuries, is time-proven evidence of respect for the dignity of the individual and thus for his or her privacy.

The importance of ministry in hospitals—privacy—is receiving less and less attention in many countries. This may certainly be partly due to the zeitgeist, but it is also not least a result of the problem that there are not enough priests. As valuable as lay ministers may be, they cannot replace the consecrated priest, who can administer the sacrament of confession and give absolution. Great demands are placed on hospital priests, and hospital ministers should never be regarded as having been put “on the shelf.”

6. What threats and limitations to privacy are there, and what must be done in order to preserve and respect it?

Visits from family and friends are generally very desirable. However, they can also become a strain, depending on their length, the subjects discussed, and the number of visitors—and the subject of illness can be a burden and cause worries. Training medical and nursing students and to be tactful is very important as regards "minor details." Tactlessness, a lack of sensitivity, and excessive familiarity vis-à-vis the patient on the part of the staff are often made even worse by insensitive visitors. The human factor as regards the staff, and the financial situation of the health system in the country and the community, have a decisive influence on privacy. Politics and totalitarian systems, as well as the economic situation of a country and the poverty of the family, play a major role.

At such an important congress, it takes a certain degree of courage to address supposed trivialities which are in fact not such for the *patient* in his or her *current* situation. The constant coming and going, people opening doors without knocking, and the hectic, restless atmosphere prevailing at certain times can greatly irritate patients. Those who suddenly see their door open while having a wash, or while on their way to the mini-toilet possibly integrated into their room, will feel seriously disturbed in their privacy—regardless of whether it is the cleaning lady arriving or a meal being brought. I may think it only natural to knock on a door before entering, but quite a few of the staff members could consider it bothersome. I need hardly emphasize that doors should be opened quietly at night in order to take a look.

Professional secrecy and the obligation to maintain medical secrecy are just as important as the seal of confession, although—if we are honest—we must admit that they are not always observed so well. Despite all the positive opportunities it offers, such as rapid availability of findings—sharing of data in case of an acute emergency, for instance—it should be kept in mind that the extensive institutionalization of medicine represents threats to privacy as a result of the increasingly extensive collection, storage, and exchange of data. However, quite apart from such situations where speed is of the essence, data exchange via computers and chip cards has become such a common routine millions of time a day that there is a need for a systematic study of these problems from the point of view of patient protection and, thus, privacy.

The book entitled *The Catholic Hospital Today? The Future of Hospitals Operated by Charitable Sponsors* contains a noteworthy chapter entitled "Attention to Minor Details" in the section "The Hospital as a Moral Subject" by Gonzalo Herranz and Hans Thomas. It says that when patients and their relatives pass judgement on a hospital, they often attach far more importance to certain minor details which could appear trivial than to the technological standard of the institution or the scientific standard of the doctors and spectacular treatment successes. The hospital must have an inviting atmosphere and be a place where people feel safe and secure. Furthermore, they say that as "Loudspeakers compete with beeper signals and alarm bells," an impersonal atmosphere can develop and television becomes the main source of noise in the rooms. The pleasure of some becomes the burden of the others, particularly in rooms with several beds. A hospital should be hospitable, as the name implies, and everyone working there should also be hospitable.

7. What can be done in order to safeguard privacy?

You may perhaps be disappointed that I have dealt with the subject of privacy more from the practical side than from a theoretical, philosophical, and sociological point of view. However, from the standpoint of the patient, privacy is primarily of great practical relevance.

A dignified solution to the space problem—single or double rooms—is a major problem when faced by scarce funds. I have already said that an experiment with "booths" as a makeshift solution is better than a large, open ward. Anyone who is involved with the sick can only benefit from his or her *own personal experience* of illness, injuries, operations, or disabilities.

Only *then* can they realize *which matters of course* are often forgotten by doctors and nursing staff in *everyday situations.* I would not say that if I had not acquired my own experience with severe, life-threatening illness, both following a cranial trauma and also after operations, chemotherapy, and radiation therapy for a malignant tumour.

The codification of the rights of the patient by the World Medical Association in its declaration of September this year is of great significance for privacy. However, paragraphs alone—as important as they may be if people are to live together—are not enough if we ourselves do not have a deep-rooted respect for our fellow human beings as patients, even though we may not find them particularly likeable on occasion! In this context, I would just like to remind you of the many "minor details" that can be avoided even without money.

You just have to think about them all the time! It is perfectly natural that the love and compassion of the Samaritan, who sees the robbed and beaten victim lying by the wayside, is not always aroused in everyday practice, with its constant confrontation with countless ill and suffering people. However, we must repeatedly remind ourselves of the exceptional situation of need in which the patient is entrusted to us. The natural right of the patient and our obligation to preserve his or her personal dignity may prove difficult to realize in primitive circumstances, when battling with scarce resources, or overwhelmed by vast numbers of patients. That we should do our best to preserve this dignity as far as ever possible, even in such situations, is a demand which is anything but new and more likely to be considered banal. Let us do our utmost never to forget it, but to fulfill it!

Dr. ERWIN ODENBACH
Neurologist and Psychiatrist,
Cologne, Germany

KARL-OTTO HABERMEHL

The Hippocratic Example of the Neutrality and Universality of Medicine

Our life is imbedded in a series of events and perceptions. Joy and fear, success and failure, kindness and menaces are the kinds of experiences we as human beings attach great importance to. All of us are constantly confronted with health issues; however, a serious illness which afflicts us personally can profoundly influence or change our previously held opinions. The fact that we are ill compels us to re-evaluate our existence, and alerts us to the finite nature of human life.

When confronted with illness, we will generally seek the advice of a doctor, in the belief that he will do his best to help us. This is true whether the illness can be cured, whether our condition can merely be improved, or whether we seek understanding and empathy when confronted with an incurable disease. According to the severity of the illness, the age of the patient, and his perception of the situation, the doctor has to make a judgment how to best serve his patient's needs. Whatever the case, the doctor-patient relationship is one that will profoundly influence the patient's life.

After mentioning the basic tenants of the doctor-patient relationship, we have to focus on some of the different criteria on which the doctor's decisions are based.

Evidently, the doctor's concern will be primarily focused on finding the optimal, most scientifically advanced method of treatment for his patient. Nevertheless, it is crucial that the doctor choose a therapy which is truly to the benefit of the patient, and not influenced by social, economic, and philosophical considerations or, worse, by "fashion."

In recent decades, this issue has been heightened as the discipline of medicine has evolved. On the one hand, we have seen revolutionary advancements in areas as gene technology, transplants, and development of pharmaceuticals. On the other hand, economic resources are more unevenly distributed than ever, and choice of therapy is often influenced by economic criteria. This dichotomy "creates are moral dilemma for the doctor, who will increasingly find himself in situations where what he can do may not be what he is allowed to do. Situations may arise where the moral principle is no longer self-evident but becomes a problem" (von Kress).

Society's efforts to establish ethical norms to guide doctors through ambiguous situations can be traced back 3500 years. One ethical guideline which is still valid today can be found in the *Corpus Hippocraticum*. The *Hippocratic Oath* postulates that the doctor must alleviate his patient's pain, support nature and its natural balance in the patient's healing, and always act to the benefit of his patient. He should not administer senseless treatment to an incurable patient who has been overwhelmed by his illness.

Though part of the postulates concern professional rules, these are no less important for the patient, since they guarantee an optimal treatment, taking into account the state of the art. Also in this sense, they help to establish a relationship of mutual trust between doctor and patient. Formulated in Antiquity, these Hippocratic guidelines of ethical behavior are still valid; for example, they are imbedded in the 1948 *Genfer Aerztegeloebnis*.

Evidently, the physician will be confronted with complex situations where the classical norms of medical ethics are not sufficient to guide him in the Hippocratic sense. These problems are universal and independent from national or geographical borders.

Despite the multitude of decisions, there is one maxim which remains unalterable:

"The consciousness of the doctor with regard to his responsibility for the patient's inspired eternal life."

1. Criteria for Decision

The multitude of decisions, the large variability regarding medical indications, the individual situation of the patient, and the social and economic conditions require a careful consideration of procedure. Among the different criteria influencing our decision, I would like to lay emphasis on some examples. Of current importance is the question of the basis of medical decision. Subsequently, one has to discuss so-called "over-technicalized medicine" and the question as to how society can afford the costs of these technological developments. To conclude, I would like to raise the question of who should bear the ultimate responsibility for the doctor's decision in a moral and legal sense.

2. The Scientific Basis of Medical Decision

Treatment of a patient according to ethical standards requires an objective and substantial medical practice. Only when the doctor's behav-

ior is guided by strict scientific standards he will be able to achieve an optimal treatment of his patients. Nebulous notions about the course of a disease or therapy, sometimes referred to as "natural methods of healing," result in treatments that are not only inefficient, but outright dishonest.

We simply cannot ignore the well-established link of theory and praxis in modern medicine, and the scientific way of administering therapy that it postulates. Not too long ago, there still was a clear distinction between theory and praxis, based on a notion of science which was developed during the renaissance, starting with the work of Bacon and Descartes.

The idea was to find universal laws through the strictly methodical observation of independent phenomena (Schieder). Medicine was considered only an applied science. Today, this notion of science is no longer valid. According to a definition of the British Medical Council, science today is only relevant if it continues, at an advanced level of research, to produce new insights, whether they are of theoretical or practical significance. On this basis, medical sciences will always seek to optimize the patient's benefit.

3. The Problem with So-Called "Over-Technicalized Medicine"

Advancing at a breathtaking pace, modern medicine has managed to combine the latest knowledge of pathophysiology and of molecular biology, as well as complicated technical innovations, with the doctor's practical work. The immense technical apparatus of a large clinic often frightens the patient. He is afraid that he might be treated like an object in a "production-line," or worse, as the object of an experiment. In fact, the opposite is the case, if we follow the ethical guidelines of our profession.

We have to consider the technical efforts in medicine in an appropriate relation. In former times, a doctor would have set a wooden stethoscope on his patient's chest; today, he is using a phonocardiogram. A nurse once measured her patient's pulse manually; today, she is using a registration device. Those are merely details, which do not change the principle of treatment. But we do have to pay attention not to lose sight of the undiminished importance of ethical norms, and of a doctor-patient relationship based on trust. This is only possible if we consider technical support as such—support, nothing more and nothing less.

Only a careful cost-benefit analysis—based on data collected in an unbiased manner—can help the doctor make his decision as to how effective, how promising and how supportable a certain therapy will turn out to be. A sound analysis presumes a detailed knowledge of all facts relating to the disease. In modern medicine, the acquisition of such knowledge is simply not possible without extensive technical support. Applied correctly, technical equipment will serve to benefit the patient, because it can protect from subjective decision-making.

4. Problems of Financing

In connection with the increased use of technical support in modern medicine, there is a constant discussion with regard to the related costs, and how they should be distributed. Those who are talking about "cost explosion in our hospitals" should start out by getting their priorities straight. I want to make it very clear that we cannot afford to give up and do without our recent technological innovations. Contrary to the opinion of a group I like to refer to as the "cultural pessimists," the technical and scientific progress in medicine is very much to the benefit of the patient.

In principle, it is unethical to deny a patient a therapy for economic reasons—meaning, because the therapy is too expensive in the eyes of whatever administration. Making such decisions is probably one of the most difficult attempts ever, because, on the one hand, we have to consider the fact that any therapeutic benefit will be limited and in all likelihood will be followed by other diseases. Furthermore, one has to take into account the finite nature of human life. What remains is usually a short-term improvement, or maybe "just" the hope for such an improvement. But it is precisely this hope which will be most important to the patient at such a time. On the other hand, society has the obligation to accomplish public tasks for the community.

These efforts can indeed improve the quality of life or even mark a centennial event. Consequently, the patient, unable to help himself in his present state, needs an advocate who represents his interests. The doctor should fulfill his duty in the Christian sense, "regarding in the patient the image of God, who lives within him, and who demands that the patient's dignity be respected" (Nakamura et al.).

5. Who Takes the Responsibility for Medical Decisions?

Even if individual medical decisions are based on clear knowledge of the subject matter and precise scientific analysis, medical decisions as a whole are continuously influenced by other concerns, both of the political and the ideological kind.

The opportunistic nature of the political process, certain fashionable ways of reasoning, or simply the lack of attention of some legislators have sometimes led to laws that cannot be tolerated from a moral point of view. In particular, I am referring to the legalization of euthanasia, and the legally binding duty for the doctor to inform his patient about all details of his illness, which understandably produces hopelessness and despair. At times, patients can be so horrified by the disclosure of all medical facts that they eventually deny life-saving treatment.

These and other shortcomings in the bodies of law which rule the medical profession are due to our government's efforts to strictly regulate medical decisions which may affect the patient's privacy. This is a worrisome trend.

In reality, the doctor-patient relationship is much too complex and individual to fit into a simple pattern. Let me quote Jaspers, who once said that "a doctor's treatment of a patient must be based on knowledge and humanity." Knowledge, just like scientific progress, is in a constant state of

flux. Humanity is even harder to measure by conventional means. My teacher and mentor Professor von Kress—a very prudent and careful man—postulated an elite privilege for medical affairs when he said: "The demands on the ethical disposition of the medical practitioner are more pronounced in this than in any other profession." Or as Victor von Weizsaecker stated "it is the doctor himself who must bear the consequences of his actions, without seeking guidance from criminal law or human rights statutes. There exists no moral philosophy which can replace his ultimate responsibility." For these reasons, the doctor's decisions are not always in accordance with national rules. The neutrality and universality of medicine is the dominant factor.

Today, rapid progress in the areas of science, technology, and economics is causing a multitude of problems. The citizens of our countries are demanding that those problems be solved immediately through government regulation, without personal involvement or responsibility of the individual. Thus countless, more or less pragmatic laws have been created, and taken effect, invading the privacy of the individual further and further. Worse, it is in the nature of these laws that they have to be revised frequently, resulting in a flurry of revisions and amendments.

6. The Correlation of Law and Ethics

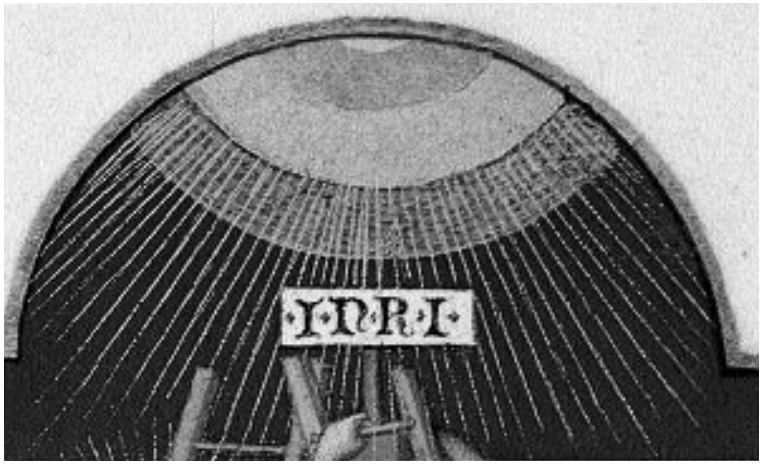
When I criticize the regulatory frenzy of our governments, I do not mean that the field of medicine should not be ruled by laws. Regarding "the task of law and order to regulate human coexistence and to avoid or settle conflicts" (Lauffs), we should aim for a system in which "the law and a sense of personal ethics complement each other, and provide a framework which allows for—and respects—the physician's moral judgment" (H.G. Koch). Within such a legislative body, it will be possible to help the patient in the spirit of the Hippocratic Oath. The prerequisites of conscientious medical practice, then, are scientific objectivity, high professional qualification, and a doctor-patient relationship built on unquestioning trust. The patient has to be confident that the doctor would never do anything which could be harmful to him, even if asked to do so.

Let me try to look at the privileged doctor-patient relationship in a larger societal context. According to Mitscherlich, two opposite problems of adaptation are influencing the individual's development in our society. On the one hand, we are capable of skillfully adapting ourselves to our environment; on the other hand, we are conservative in protecting our individual values and rights. The question is, if in the development of mankind, one should favor the individual personality, able to think in alternatives, or the human capability to perfect the role one is meant to play.

Which is the benchmark we should measure ourselves against: Whether we are able to defend our own values and rights while recognizing those of others? Or whether we are able to adapt ourselves with a minimal amount of friction to organizations, laws and regulations, which govern our lives? In the latter case, we will misuse our own abilities and talents in such a way as to change our very mind-set, and we will thus destroy the basis of our free existence.

"Responsibility presumes freedom," as Dietrich Bonhoeffer said. No authority is competent to release the doctor from his freedom for a medical decision. Let us make sure that the integrity of our work continues to justify the underlying principle that our medical service should be done in "freedom of responsibility," serving the patient's inspired eternal life.

Professor KARL-OTTO HABERMEHL
Director of the Institutes for Clinical and Expermental Virology
at the Free University of Berlin



JESÚS CONDE

Suffering and the Meaning of Life

Introduction

Perhaps more than any other reality, suffering has been described, studied, thought about, and expressed, in all its various aspects and dimensions. Suffering is without doubt a reality which cannot be reduced to a question of mere scientific analysis; in the same way it cannot be tamed through the use of philosophical techniques and reflection. It is perhaps for this reason that the discovery of a meaning and a significance to what is a very universal experience is so very problematic and so rife with controversy. In the same way, and despite the human thirst for understanding and dominion, such a quest remains notably unenlightened. From this point of view, and here an initial approach may be adopted, one could perhaps say that human beings are divided into two major categories: on the one hand, there are those who believe that there is a constructive and benevolent meaning to life which is be found in, and is revealed by, suffering—and this despite the fact that it is an evident evil—and, on the other, there are those who deny that there is any possibility of there being a meaning to suffering and believe that its only meaning lies in its exclusively destructive character.

In order to deal with a subject which as large and demanding as that which has been given to me, I think it is necessary to make certain initial specific observations. In the first place one should stress the fact that this international conference, like those which preceded it, has been organized by the Pontifical Council for Pastoral Assistance to Health Care Workers—that ministry of the Holy See which is dedicated to the promotion of pastoral assistance in the health field within the universal Church and in the world as a whole, and which seeks to serve in the name of Jesus Christ.

One should add that it is precisely in this pastoral field that I have acquired that experience, over I might add the space of twenty-six years, which enables me to say something useful about "*suffering and the meaning of life.*" And I would like to also observe that I also believe that pastoral work is—and must be—that activity which wisely and strongly integrates the *practice* of caring which comes from the gospel imperative of the Church into the *recta ratio agibilium*, that is, into the *thought and reflection* which is expressed in the form of "*know-how*" in the field of pastoral action and in relation to other forms of medical and health care knowledge and practice, whether Christian or secular, and which, through the use of dogmatic theology and medicine, gives rise to a reawakening of the those eloquent symptoms and forms of science which find themselves hidden in facts and experience.

Another preliminary observation is called for and this relates to the title of this international conference—*"From Hippocrates to the Good Samaritan."* The history of Western culture, medicine, and health policy and care, has bestowed a special importance on these two famous individuals. They have become figures which are highly emblematic when it comes to the treatment of the suffering of others which is caused by wounds or illness. Thus it is that when we consider these two figures today they constitute two models which are full of significance and relevance. For this reason they are important sources of meaning for health care workers engaged *(at times) in trying to heal (often) in seeking to reduce suffering, and (always) in striving to console and comfort.* They of the same importance to those, who, through the exercise of their own profession or through voluntary pastoral or health care work, seek to rise to the challenge of the Sermon on the Mount: *Blessed are those that suffer for they will be comforted.*

Bearing these preliminary observations in mind, I think one can say something valid about: 1) what kind of *meaning* can be given to one's own life and be given to the lives of other human beings, who, it may be observed, nowadays tend more or less consciously to identify with Hippocrates and the Good Samaritan, when there is a drawing near to patients—in the literal sense of the term—with the aim of caring for them in a way which corresponds to this identification[2]; *what convergent and what divergent features* are today displayed in general terms by these two figures after their long journey through history; and[3] what the Church can do, and in more practical terms what pastoral assistance can do, to obtain the best and most complete *union* possible between today's versions of *Hippocrates* and today's *Samaritans* to ensure that a real human and Christian meaning is given to life—that path which for us all remains a *via dolorosa.*

1. Hippocrates, the Good Samaritan, and Suffering

As a priest destined by the Church to provide pastoral help not only to sick patients but also to that broad range of other patients who care for them—that is, relatives, health care workers and volunteer workers—I have been and I am at the present

time a witness to how the members of this second category of patients deal with the suffering of others and are affected by the suffering of others, and how they express the impact of this suffering in many different and specific ways. In many of these people, and, above all, in the *volunteers and professionals engaged* in health care work and service, I can perceive the incarnated figure and the various features of both Hippocrates and the Good Samaritan.

I will leave to historians of medicine and to bible scholars the task of defining and outlining the extent to which, and in what ways, the two figures in question can be applied to present- day realities and conditions. From what medical history and bible scholarship says on the matter, I would like to describe, from the point of view of a priest, only those features which give a meaning to life, taking as my starting point the suffering which is experienced in caring for sick people. In this general approach I would like to make clear that I detect the figures of Hippocrates and the Good Samaritan in the health care workers of today's world. This certainly leads me, and indeed compels me, to pay attention—albeit in a superficial and selective way—to what historians and bible scholars have said about these two important figures.

1. Three texts from the *Hippocratic tradition* should, I think, suffice to bring out the approach of the followers of that tradition to the suffering of sick people. These three texts are as follows: "The physician transmutes the pain of others into his own worry" *(Escribonio Largo);*[1] "*when faced with the pain of others the physician suffers his own pain"* (*De Flatibus*, L. VI, 90);[2] "*The aim of medicine is to free sick people from suffering, alleviate the acute attacks of illness, and to refrain from engaging in the treatment of those who are overwhelmed by illness, in situations, that is, when it is known that the science and practice of medicine can do nothing in practical terms to help the patient (De Arte)*.[3]

The second quotation makes very clear that in a certain way the Hippocratic physician takes on the pain of his patient. In the second quotation we are struck by the fact that this process leads the medical doctor to suffer. From the third quotation we can deduce that these two facts—that is, the taking on of the pain of another person by the physician and its conversion into suffering—were consequences which were not unforeseen or a matter of chance but were an integral part of health care and *sought to liberate sick people from their suffering and alleviate the consequences of the acute attacks of illness.* Thus we can see that the inventors of the science and practice of medicine—a rational and applied form of technical knowledge—demonstrated that they were actual participants in the pain and suffering of their sick patients.

For what reason, in what direction, and to what extent did the followers of Hippocrates believe that *compassion in health care* was both required and possible? The basic reason behind their stance lay in the fact that the Hippocratic struggle against suffering had deep *religious* roots. These roots, it may be observed, were also *religious*.[4] Their idea of being as being made up of nature *(physis)* and principle *(arché)* in the organization of the elements *(isonomía)* in their total unity *(kosmos)*, led the Hippocratic physicians to see infirmity as an imbalance *(monarchía, dyskrasía)* and a disorder *(chaos)* and to consider suffering as a painful consequence of this condition *(pathos, lypé)*. They thus believed that infirmity and suffering were unnatural realities.

For this reason the duty to combat suffering had an almost religious significance which was expressed by a Latin maxim which clearly has Hippocratic origins: "Divinum opus sedare dolorem."[5] What is natural, therefore, is necessarily indifferent and apathetic *(apathés)*, and in the divine order there is no suffering. It should therefore be observed not only that the form and kind of medicine which we now call Hippocratic was born and developed in imperial Greece but also that it had this specific *physiological religiosity* as its fundamental base and ideological foundation.

The chief orientation, course, and direction which this form of medicine employed in its struggle against pain involved the elaboration of a technique *(techné)*, a word which expresses the brilliant discovery of the Greeks about the importance of applying knowledge to nature. In opposition to the magical or merely "trial and error" style of medicine of previous ancient cultures, Hippocratic medicine (and thus also that of Crotones, of Cnydos, and so forth) used the capacities of the human mind to understand, and to understand in natural terms, the suffering associated with illness and to combat that suffering through *techné iatriké*, a form of knowledge which was based upon the why and the how of the procedures which were employed in the treatment of suffering.

Hippocratic medicine, amongst other things, contributed to the history of treating and caring for human suffering by producing the *imperative of knowing how to provide assistance*. This involved the clear and evident reality that when faced with the suffering of sick people good will was not enough unless there was also an *effective process of treatment.* For this reason it was believed that the physician who wanted to be (ethically) sound had to be first of all a physician who was well prepared and competent in his work.

To what extent did compassion in the provision of assistance bind the Hippocratic physician in the exercise of his profession to the suffering patient and lead him to suffer with him and for him? The answer which is to be found on many occasions in the texts of the *Corpus Hippocraticum* seems clear: the physician was to do this as long as the inexorable laws of nature allowed the physician to reduce and eliminate the suffering of the sick person through the practical application of the art of medicine. That is, that the Hippocratic physician could unite active compassion to treatment in his relationship with the patient only if he believed that his methods could be effective. The above-mentioned text *De Arte* makes clear that "*The aim of medicine...is refrain from engaging in the treatment of those who are overwhelmed by illness, in situations, that is, when the science and practice of that medicine in practical terms can do nothing to help the patient."*

Hippocratic medicine thought that certain illnesses overwhelmed the patient because of nature itself *(kat'ananken tes physeos)* and that the use of medical knowledge and skill in such circumstances was not only useless but even wrong because it involved going *contra naturam*. Such illnesses were held to be technically, morally and religiously incurable. Other illnesses, on the other hand, occurred by chance *(thyké)* and together with the suffer-

ing which they produced were the true objects of the profession of treating and curing. The radical naturalism of the Hippocratic school extended the understanding and the practice of *philanthropia* (love for one's fellow man) of the physician in relation to the suffering sick person only to the point where it was possible to re-establish the perfection of nature in that patient -by which was meant the re-establishment of the sick individual himself.

It should be stressed that the ethics and the religious beliefs of the Hippocratic physician prevented the taking of steps beyond this point. The human being was considered in terms of nature alone and it was necessary to hold to this belief. The personalist conception of the human being, and thus also of the suffering sick person as well, was foreign to ancient Greek thought. This conception and approach emerged with Christianity which went beyond the limits of Hippocratic naturalism and provided a new perspective on treating and caring for the sick. Christianity also supplied an imperative and alternative forms of initiative which were both new, and from a certain point of view also limitless.

2. At the side of, and in front of, the figure of Hippocrates this international conference has placed the figure of the Good Samaritan. I believe that this is not only due to the fact that he is Christian model for concern for the sick but also because, and here I use the expression of John Paul II, he has "*become one of the essential elements of moral culture and universally human civilization.*"[6] Indeed the Pope also observes that "*not without good reason in common language as well we term a work of the Good Samaritan every action taken on behalf of men who suffer and of all those who need help.*" What is there in this figure which has made him transcend his historical and literary time and epoch and come down to us, and has led him to continue to be a symbol for those who today look after the suffering? Pope John Paul II gives an answer to this question which is both direct and clear through the employment of three successive statements[7] which illuminate the meaning and implications of the figure of the Good Samaritan:

a) The Good Samaritan is *every man who unites himself to the suffering of another man, whoever that person may be...every man who is sensitive to the suffering of others.* In relation to the wounded man, whom the parable presents as the typical representative of those men to whom we should show compassion, the Samaritan is the sign of a universal human approach towards suffering which involves being moved and then deciding spontaneously *to draw near* to the person who suffers. In relation to the practical world of treating and caring for the suffering, the Samaritan is the live expression of the fact that assisting a sick person (and here no attempt to achieve perfection is intended), whether

effected by a medical doctor or by a non-professional figure, is an act of love—of a love which comes before scientific and technological knowledge and prior to the prescription of drugs.[8]

But what meaning—what kind of appeal—does the word "love" have in the strictly Christian context of the parable of the Good Samaritan? Pedro Laín Entralgo, the eminent medical doctor and a Christian by vocation, answers this question in way which in my opinion is so effective that I have no alternative but to summarize it here: *For Christians, love—open love—has a religious and metaphysical coherence which imposes three commandments:* a) love your neighbor as yourself (where the term "neighbor" is understood in the Christian sense of any human being in a state of need to whom one draws near). *This is the teaching of the parable of the Good Samaritan. The new departure as regards Greek thought is both clear and fundamental.* b) Love your neighbor as if he were Christ. *This is the moral lesson to be found in the eschatological passage from Matthew 25:39s: the least of my brethren are, in general, all those human beings who for one reason or another need company and help.* c) Love your neighbor as though you yourself were Christ. This is what the passage from John 15:12 (among other passages) makes clear: love one another as I have loved you. *The Christian must love others in the same way as Christ loved.* [9] For the followers of Jesus Christ, the contribution of loving self-giving to those who suffer is limited at the outset solely by the prudence and the practical humility which *human frailty* necessarily requires and involves.

Christ is the purest incarnation of the Good Samaritan when we come to consider this initial approach of placing oneself at the side of those who suffer. The gospels clearly show how Jesus could not be in the presence of suffering without being deeply moved. On seeing that the people who had come to him were "*harassed and helpless*" (cf. Mt 9:36) he "*had compassion for them*" (see also Lk 7:13) and was upset. These sentiments and feelings were the emotional basis and the primary impulse which set his work as a healer in motion; and he was a healer bearing a universal *philanthropia* which did not exclude anybody. For the Samaritan-Christ, as St. Paul would later say, "*there is neither Jew nor Greek, there is neither slave nor free*" (Gal 3:28) when we draw near to those who suffer in order to be a neighbor in the most fundamental sense of the term, acting, that is, beyond the limits imposed by Judaism or by Hippocrates. "*Who is weak, and I am not weak? Who is made to fall, and I am not indignant?*" (2 Co 11:29).

b) Pope John Paul II goes on to say that the Good Samaritan "*is he who offers help when there is suffering...whatever kind of help that may be; effective help, wherever this is possible.*" This action is what makes the Good Samaritan the allegorical symbol of *health care workers*—whether they are professional or volunteer—at all times.[10] It is no exaggeration to say that the ministries and the activities of the Church in relation to those who suffer, throughout the whole of the Church's history, have arisen from an approach based upon ideas of

voluntary service and inspired by the model of Christ, the Good Samaritan, the Shepherd who *has come to offer his life* (cf. Jn 10:17), who was sent to "bind up the brokenhearted" (cf. Is 61:1). This is an example which has come down to our own days and which inspires *all those who render service to their suffering neighbor, and freely dedicate themselves to helping others as the Good Samaritan did.*[11]

And the same may be said of medical doctors and other Christian health care workers.[12] Ever since the moment when Christianity absorbed Galenic-Hippocratic medicine into its project of health care in definitive fashion, for medical doctors of the Christian faith the figure of Christ the Physician[13] has continued to be the figure of the Good Samaritan adapted to new circumstances and conditions. In this way one can see that Hippocratic *philanthropia* has been united with Christian charitable initiative, and technical capacity has been linked to the contribution of voluntary work to the health care sphere. All this is expressed in the offer of help to those who suffer, in a shared attempt to convert compassion into an effective contribution to the comforting of pain. Yet it should be pointed out that at the initial moment of this fusion the newness of Christian feeling and the radical nature of its imperatives were certainly more than evident.

Early Christianity itself was able to create a more than valid system of health care which was based upon *voluntary action.* This was more than natural given that for the first century and a half of its history Christianity could scarcely rely upon the help of Hippocratic medicine.[14] The first Christian communities showed how a lack of economic and technological means and resources were not an insurmountable obstacle to giving suffering people a form of care which matched their needs. This lack of immediate resources was compensated for with human and spiritual forms of care and treatment. The infrastructure of such care was based, above all, on those human resources which arose from, and were provided by, the community itself. From then until our days this has been the dominant feature of the history of voluntary Christian health care and service.[15]

When we consider and examine the professional care provided by Christians we should examine a series of new departures, beginning with the perspectives of the gospels, namely: the overcoming of the contrast between assistance and treatment, a contrast which, it might be pointed out, is deeply rooted in modern and contemporary medicine[16]; the practice of *"a kind of verbal or psychological psychotherapy of a moral and religious character...aimed at the creation of a correct intellectual and emotional framework by means of which the sick person can understand the painful trial which his infirmity represents";* the acceptance of the idea that the Christian doctor should take care of the incurably ill and the dying—something very different from the moral and therapeutic detachment of the ancient Greek physician and of many other kinds of doctors even today; and, finally, the moral and therapeutic value of *living with pain.* This new departure brings me to the third observation made by Pope John Paul II.

c) The Good Samaritan is the man *who is able to give of himself.* In this idea we find deeply embedded the most profound aspect of what I have sought to emphasize in this paper the achievement of that personal involvement in care for patients which is required from the Christian voluntary or professional health care worker. From the Hippocratic tradition it appears clear that such care involves a certain *"dolorido sentir"* for the physician, to employ the excellent phrase used by Garcilaso de la Vega y Azorín. But how great should this involvement be? I believe, once again, that in truth it is the really the Christian tradition which brings out the true depth and the requirements of this involvement. Let us now briefly turn our attention to how this is so.

The Gospel according to St. Matthew, in its description of the healing activity of Jesus, brings out the personal price that those who engage in health care assistance (whether they are professionals or volunteers) must pay when that assistance is completely and profoundly human. According to the text to be found in Matthew 8:16 ff., Jesus fulfilled the prophecy of Isaiah when he engaged in healing: *"He took our infirmities and bore our diseases."* Reading this passage, and that from Isaiah 53:4, where reference is made to health care, one should observe that the technical element is certainly necessary but it is not in itself sufficient in every action of healing and treatment which is not merely narrow in character. In other words, such an action should not be a mere question of providing a diagnosis and of following and prescribing a treatment which is technically impeccable.

It should be, rather, a constant and interacting human relationship which gives force and strength to the healer so that *he can give of himself and take on the suffering of the patient.* He should give a larger or smaller part of himself, of his own inner self, according to the seriousness of the case he has to deal with. He should also take upon himself a part of the suffering felt by the sick person, whether that suffering is of a organic, physical or mental character. The healer and physician who wants to act in imitation of Christ, the Good Samaritan and the *Healer of souls and bodies,* must be aware of the fact that care for the suffering of others means that to a certain extent he also must fall ill in order to be the *wounded healer* of the suffering of patients and thereby contribute what *was lacking to the passion of Christ, through* (the consolation of) *his body, which is the Church.* (cf. Col 1:24).

2. The Suffering Which is Involved in Caring for the Sick

Unfortunately this subject attracts very little attention on the part of present-day health care institutions and in relation to the general pastoral work of the Church. This is not true however when we come to consider the psychological and pastoral studies which have appeared recently on the phenomenon of *"burn out,"* on the drying up of practical care when people are faced with and have to deal with the suffering of others. Nonetheless, such "burn-out" is an incontestable fact which any careful observer is able to pick up on and which is encountered every day by those who practice pastoral work in the field of health care. For this reason I have thought it opportune to pay attention to the subject of pastoral care and to leave to one side those other elements which go under the general heading of *suffering and the meaning of life.*

I would like to produce observations derived from my own experience of pastoral work which has been carried out in the name of the

Church. The correct practice of pastoral work in the health care field does not only involve the carrying out of actions which are central to such work. It also provides a privileged observatory of objective signs and subjective symptoms which are manifested in those who receive such pastoral care. These are signs and symptoms which must receive the attention of all the disciplines involved in health care—disciplines, for example, such as anthropology and theology.[17]

I would like to begin by giving a brief and simple exposition of the semiology and the symptomatology which the pastoral observer detects in the health care workers who take care of those who suffer.[17] I will begin with the *voluntary* workers. In the eyes of society and the Church such people seem to be the reincarnation of a form of philanthropy which was thought to be almost extinct. For this reason they are a precious *symbol* which everybody strives to the utmost to bring to the attention of the public. For very many institutions which have to deal with the world of suffering, these people constitute a veritable army of individuals who by their vocation are ready and willing to carry out tasks whose character clashes with the mentality of a society which is based upon superficiality and hedonism.

On the whole, these people are well qualified to perform this task with skill and efficiency but the help that they need goes well beyond their training. The *price of pain that* they have to pay in order to be loyal to their vocation as Samaritans shows itself in the worried concern that they display about whether they are really up to the tasks that they are entrusted with. They are troubled by the fact that at times they do not know where or how to lighten the suffering that they have to deal with and which is thrown in their direction. They have the feeling that they do not receive sufficient attention and esteem from the institutions they work for. These facts are often experienced with that sensitivity which is natural to pastoral assistance in the health care field, and many of these Samaritans often display a distinctive constellation of symptoms: tiredness, instability, disappointment, and bitterness. And if these emotions are not perceived and dealt with in suitable fashion they can lead in the best of cases to a notable reduction of effectiveness and efficiency; yet at times they also lead very deep mental and spiritual crises.

Health *care workers,* and here I also refer, of course, to Christian health care workers, often find themselves in the same situation.[18] It is widely believed that as a general rule they are immune to the suffering of the sick people they care for and treat, and are also insulated against the suffering of the relatives of these patients. Indeed, it is often believed that their profession gives these people a kind of emotional armor-plating. In actual fact health care workers often

instill a feeling of security in sick people and their relatives: "*by now you are used to seeing illness and suffering*" is a sentiment which is commonly expressed.

There are three principal *reasons* behind this widespread attitude. First of all there is the image that society has of health care workers, people who are seen as the technicians of health and health care and whose effectiveness and efficiency seems to be accompanied by a cold scientific objectivity which renders them insensitive to the suffering and emotions of other people. The training and education of the health care workers is another factor. Indeed, their studies involve an emphasis on scientific disciplines and there is tendency to neglect the *human dimension of things* (including spiritual care) in their training programs. Finally, reference has to be made to the efforts many health care workers make to defend themselves from the very enormity of the suffering which they have to deal with every day in the course of their work, those efforts which involve an attempt to establish a distance between themselves and their patients. They seek to justify this stance with reference to the need for balance and for scientific and technical objectivity but in so doing forget that anxiety is more infectious than pathogenic micro-organisms. A great many of these Samaritans need a diagnosis and forms of treatment which are both human and pastoral in character and which will lighten the inevitable suffering which they *take upon themselves* and which will compensate them for the energy they have lost through their great efforts!

In reality anybody who has the least human or pastoral sensitivity and sensibility can very easily discover that health care workers need help and substantial support which is usually not available in health care institutions and indeed is not even forthcoming, when such workers are Christians, in the Church itself. We might give a list here of what the needs of health care workers in this field really are:

The need to give expression to what they feel, a need caused by the systematic repression of their feelings which arises from repeated contact with the suffering of sick people and their relatives; and the need to have suitable channels for the expression of such feelings.

The need to counter and compensate for the many complaints and criticisms which sick people and their relatives often make, some of which are caused by the negligence or false steps of health care workers themselves but which are also often the result of the defects in the health service itself, of which they themselves are the victims.

The need to secure satisfaction in a demanding kind of job and form of employment which usually does not offer many rewards to those who perform it.

3. The Contribution that the Hippocratic Individuals and the Good Samaritans of Today's World Make to the Meaning of Life

The question of the contribution to the understanding of the meaning of life when that life is in contact with suffering, something of course which happens when the sick are looked af-

ter, can and must be answered with two other questions in order to make sure that a full and complete—but at the same time short -answer can be given.

The first question is highly conditioned by the fact that suffering is a sign and relates to the meaning that this sign has for those who see it as a result of their contact with patients. The question is as follows: what meaningful aspects of life, which are not present in other forms of experience, do health care workers come into contact with when they care for the sick? The answer necessarily involves a number of steps. First of all, they encounter one of the most lacerating forms of the presence of *evil* in the world and they thus come up against the sign of the inherent *infirmity* which St. Paul perceived in the whole of the Creation.[19] Indeed, it should be pointed out that all human cultures have seen suffering as an evil which should not really exist.

But differently from those who have argued and continue to argue that we should distance ourselves from our own suffering and from the suffering of other people[20] people like Hippocrates and the Samaritans of each and every epoch have detected a form of human penury in suffering—a poverty which can be treated by anybody who helps those who suffer from its effects. Suffering, therefore, is a *reason for human progress*, progress, that is, which is both physical and psychic, scientific and spiritual. The Hippocratic tradition believed that suffering, and the infirmity of which it was the sign and expression, involved a challenge to man's ability to introduce order and harmony into chaos through the use of reason and through the employment of instruments invented by the human mind.

On the other hand, the Samaritan tradition, by which I mean the Christian tradition, involves an invitation to ensure that not only natural and rational resources are mobilized against suffering but the whole of the person and personality of the individual who provides treatment and care.

This, in turn, involves drawing upon the resources of the redemption of Christ, the *Healer* who made himself *Servant and Patient* and through this triple capacity (which was expressed in unified form in his own Person) was able to cure, to lighten and to console. Only through Christianity can the health care worker who is engaged in caring and curing discover his fundamental human character— understand, that is, that he is both a pauper and a donor, that he is at one and the same time both in need and able to help those who are themselves in need.

The second question directly involves the state of mind of those working in the field of health. This question is the following: what kind of orientation does the experience of looking after the sick impart to the life of health care workers? Because of their contact with suffering, a suffering examined and felt through their care for patients, Hippocratic people have secured a constant advance in medicine which has continued until today and will progress even further into a future which will be even more extraordinary. These are workers of a technical miracle, and for Christians they express and bear the *ordained power of God* in their curative actions.

The health care Samaritans, on the other hand, encourage us to work for an ever more overall form of care and treatment which can provide an answer to the various aspects of suffering which a patient undergoes, whether of an organic, psychic, social or spiritual character, beginning with these very same dimensions, which of course are also shared by the volunteer worker or the professional practitioner. Once again the model and inspiring example for this *integral process* is Christ. As the New Man, he is, of course, the representative of total synthesis which in the case under discussion involves a fusion of patient and healer; figures which are present, become integrated, and also become transformed in his person.

To conclude this paper it should be observed that Christ is that meaning to life which today and in the future requires a grand alliance between Hippocrates and the Good Samaritan, between intelligence and feeling, between reason and will, between science and faith, between technology and charity, and between treating and caring. In health care pastoral work we see matters from this point of view. And taking this form of pastoral care as our point of departure, we call upon the whole Church to give a strong and resolute impulse to this alliance within her own life and structures, and to ensure that all Christians become ever more concerned to *assist those who assist* so that as a result of their wounds, like those of Christ himself, everybody else and they themselves *will be healed.* (cf. 1 P 2:24).

Rev. JESUS CONDE
Archdiocesan Delegate for Pastoral Care in Health, Madrid

Notes

[1.] Quoted by PEDRO LAIN ENTRALGO in *Historia de la Medicina* (Salvat, Barcelona, 1987), p. 135.

[2.] Quoted by the same author in *La Relación Médico-Enfermo* (Alianza, Madrid, 1983), p. 98.

[3.] Quoted by the same author in the same work, p. 99.

[4.] The observation is made by DIEGO GRACIA GUILLÉN in "El Dolor en la Cultura Occidental," in *Fe Cristiana y Sociedad Moderna*, vol. 10 (SM, Madrid, 1982), p. 27.

[5.] D. GRACIA GUILLEN, l.c.

[6.] JOHN PAUL II, the apostolic letter *Salvifici Doloris*, Feb. 11, 1984, no. 29.

[7.] JOHN PAUL II, *Salvifici Doloris*, no. 28.

[8.] P. LAIN ENTRALGO, *La Relación*, p. 105.

[9.] P. LAIN ENTRALGO, *op. cit.*, pp. 107-108.

[10.] *"La concepción de la asistencia que dimana de la doctrina y conducta de Jesús imprimiió una evolución decisiva a la cultura y la praxis sanitarias de Occidente y, a travs de ellas, a las de toda la humanidad"* (J. CONDE HERRANZA, *"La Aportacion de la Iglesia a la Sanidad,"* in *"Evangelio y su Propria Tradición,"* Labor Hospitalaria: Organización y Pastoral de la Salud, no. 223, 1992, p. 72.

[11.] JOHN PAUL II, *op. cit.*, no. 29.

[12.] This is recognized by the present Pope as well in a paragraph of this apostolic letter: *"There is a great deal of the Good Samaritan in the profession of the medical doctor, of the nurse, and of other health care workers."*

[13.] For a discussion of this title, its meaning and its implications see the magnificent study of MANUEL GESTIERA GARZA, *"Christus Medicus: Jesús ante el Problema del Mal,"* in Revista Española de Teologia, 51, 1991, pp. 253-300.

[14.] See D. GRACIA GUILLÉN, *"El Cristianismo y la Asistencia al Enfermo,"* in Labor Hospitalaria: Organización y Pastoral de la Salud, no. 184, 1982, p. 67.

[15.] For a more detailed discussion of this point and the others that follow see J. CONDE HERRANZ, op. cit., pp. 73-77.

[16.] P. LAIN ENTRALGO, *op. cit.*, p. 128 ff.

[17.] A more detailed and complete pastoral contribution to this subject can be found in the various works published in the separate monographic publication of *Labor Hospitalaria* dedicated to "El Sufrimento en la Enfermedad. Claves para Vivirlo Sanamente," no. 235, January-March 1995.

[18.] See J. CONDE HERRANZ, *"Los Cuidadores del Ser Humano Enfermo,"* in *"Introduccion a la Pastoral Sanitaria,"* Delegation of Pastoral Care in Health to the Archbishopric of Madrid, September 1994, pp. 22-24 (document for internal circulation only).

[19.] In Rm 8:26 St. Paul calls this *"our weakness"* and extends it to the whole of the creation in verses 19-22.

[20.] For example, and for different reasons, ancient stoicism, Buddhism at all times in its history, or the *modern religion of "happiness,"* which is still very widespread in the West.

STANISLAW GRYGIEL

The Civilization of Sadness and the Culture of Joy

> *"Supernatural remorse leads to an abiding and salutary change of heart, whereas the world's remorse leads to death."*
>
> (2 Cor 7:10).

Man wishes to live more fully. He knows what he must do to have abundance. It is not clear to him, however, what he must do to satisfy his wish to be more fully. To be to the full is something very distant and the paths along which he treads during his miserable present only lead him to another present which is equally miserable and short-lived. Man not only wishes to be more fully—he also feels himself called to be in such a way and he is thus responsible for his response to such a call. The task of being to the utmost, therefore, is entrusted to his freedom. But where are the paths of this freedom? Without any doubt they are reached "through faith" (*Heb* 11:8-9) and hope. Indeed, they lead beyond time and space, dimensions in which only things to be possessed exist. But where do these paths begin? Man becomes afflicted by great sadness and anxiety because he knows that upon himself alone rests the responsibility of whether this sadness "will turn into joy" (Jn 16:20) or whether it will start to degenerate into "irrevocable" despair.

"A man was going down from Jerusalem to Jericho" (*Lk* 10:25-37). By means of the parable of the Good Samaritan Christ answered the question posed by the learned man of law: "what shall I do to inherit eternal life?" The lawyer knew that man can speak about eternal life only in the form of a question. He did not know, however, that the answer is not to be found in a particular sentence but in a change in the direction taken in life. The wish for a fuller life which expresses the desire to be, and not to have something or other, opens man to the religious dimension to life.

The word "religion" comes from the Latin term *relegere*—that is, "bind," "collect into one," "read," and 'walk.' Man reads the text which is he himself and other people, he collects it into a whole and reads it with He who has written it. At the same time the good of the truth which is given to man in this text unites his love with He who has loved man from the very beginning in the act of creating everything that exists.[1] It is precisely from this starting point that man walks towards God or, in other terms, it is here that he loves Him "in spirit and truth" (*Jn* 4:24).

Eternal life awaits all those who love God and their neighbors as themselves with all their hearts. When the lawyer asked "who is my neighbor?," Christ showed through the story of the compassionate Samaritan that the question had been asked in the wrong terms—do not ask who your neighbor is but become the neighbor of other people! Change the direction of your existence! On the road which led from Jerusalem to Jericho the priest and the Levite were also to be found. But they passed the wounded man by without caring about him and without concern. They did not change the direction of their existence. They were not "moved" by the injured man and they remained unaffected. They did not read what was written and did not love the good which was revealed in his injured condition. Their affairs which they had to deal with in Jerusalem meant that "their eyes were kept from recognizing him" (*Lk* 24:16). Thus it was that their failure to recognize the truth and the good in another person meant that they failed to do that person justice. They also failed to do themselves justice. They allowed themselves to be guided not by what was revealed in the experience of the presence of another individual—a presence which places moral obligations upon us—but were guided by things to do and to have in Jericho. Thus it was that they passed by that man who called (like Job) for justice for his wounded dignity.[2] In their mentality—which is so similar to our scientistic way of thinking—there was and is no place for a sacrifice of one's own ideas for the sake of truth and for the good of man.

The formalism of the priest and the Levite blinded them to what was really before them and meant that they failed to create a story worthy of being told. The time of their going to down "from Jerusalem to Jericho" is a time of emptiness—nothing happens. They remain within the Gospels as images of people who in banal fashion go nowhere and are convinced that it is precisely there that they will deal with the questions bound up with the meaning of their lives. They approach this meaning as if it were a "riddle" to be solved with the help of powers of reasoning. In passing by another person in indifferent fashion they detach their minds from the truth and the wish for that good which has been given to their freedom—that is to say to their faith, hope and charity. They think they know what the evil is that consumes the man. They believe therefore that the truth and good of his being depends on them. As a result, they give voice to mere empty gestures and refrains which are repeated in a sort of ritual fashion.

The "little prince" would call men of this kind mushrooms swollen up with their own pride.[3] Thus it is that license produces pride and refuses to receive the gift of other people. The person who has already solved the riddle of man comes to treat him as an object from which nothing can be expected. He passes him by, therefore, and enters "Jericho" with the same unthinking impudence with which Oedipus entered Thebes after solving the riddle posed to

him by the sphinx. But although he experienced power and pleasure in that place, both he and those dear to him were to meet a tragic fate. A civilization which distances man from man directs the ecstatic existence or rather the spiritual life of individuals towards the void. They go out from themselves but go towards nothingness and fall into an unthinking revelry and desperate sadness. Their wish to live more abundantly puts roots not into what is, but into a praxis which has been calculated in Promethean fashion. Their love and their knowledge are deprived of good and of truth and fold in upon themselves, losing themselves in a search for effective means by which to produce comfort and pleasure. Their spirit is sick. The falsehood of intelligently constructed illusions devastates their minds and makes slaves of their wills. Where there are no meeting points there is only that which does not exist—the void.[4]. In the bible the void and sadness which spring from this absence appear for the first time in Caine (cf. *Gn* 4:6). Caine believes that he knows the significance of the evil which torments him—he sees its cause in the specific presence of his brother. He observes the latter's happiness with envy and does not realize that Abel receives that happiness in an opening of himself with elevated realism to the divine dimensions of his own existence. Caine moves in sterile fashion in the void of equations of pure reason. Subordinating himself to their mechanics he tries to be more abundantly through the possession of things more abundantly. But unfortunately this does not transform the human being. As Plato would have expressed it, Caine ceases to be a "demoniacal man"[5]—that is to say a spiritual man, an expert in questions which are of decisive importance for the meaning of his life—and becomes a "mere workman" who knows some "trade" or other. Closed within this "trade," he carries death for other people within himself rather than becoming their neighbor. The spirit decides the character of the moral conscience of man. A sick spirit means a sick moral conscience.

"Nobody is as sad as I am.... I look into myself and see what I am...dead. Did I say I was sad? I lied. The desert, the incalculable nothingness of the sands beneath the lucid nothingness of the sky, is neither sad nor gay: it is sinister. Ah! I would give my kingdom to shed a tear."[6] For the King of Argos, who utters these words in Jean-Paul Sartre's work *Flies*, the "trade" of dominating the mechanisms of social-political-economic nature has made the presence of other people useless. As a result, he is not present even for himself. In line with equations which enable him to be something but not to be somebody, the time of jealous love for Antigone—the time dedicated to other people—is time lost. In a world created by spiritually sick people, each and every Antigone will be condemned to death.

Truth entrusts its mystery to man in a way which is proportionate to the extent to which he exists in dialogue with another man. It flees from those who in solitude, and thus in sterility, construct opinions which are "shadows" of truth—that *doxa* process of Plato's cave of slaves, or the matters to be dealt with in "Jericho." Truth and good are unable to bear the work of truth and good. Illness of the spirit leads to sloth (*acedia*). Man is then besieged by sadness and worry (*anxietas*, *augustia*) about hidden evils and at times by the good in others—as if this caused evil to himself (*invidia*)[7]—which paralyzes the mind and the will. Man becomes inert not only in knowing truth and loving good (*agere*) but also in external activity (*facere*).[8] Sloth thus links up with despair.

The priest and the Levite certainly had houses but they did not have a home in which to be themselves. A home can only be built *in communione personarum*. The pusillanimity which prevents them from stopping next to another man has made them become individuals who are homeless. The homeless do not constitute a society but an appearance which is called a crowd. The crowd is always full of sloth. Its activism is none other than another form of sloth. The inability of spiritually sick people to take creative decisions and to perform creative works means that within society *ars gubernandi*, which is an extension of *ars creandi* [9], becomes replaced by what I would term *ars administrandi*. In an administrative, logical, empty and workless functioning, *ars dominandi* becomes the logic of social relationships. The struggle for the functions of administration is accompanied by servility. This latter gives rise to merely apparent politics whose purpose does not involve, as Aristotle would have said, "promoting friendship" (and thus also justice) because "justice and injustice take place above all else between friends."[10] In the crowd men are not so much worried about the building of a common home but about their own interests in opposition to the laws which govern a shared home.[11] In this way we observe that an apparent economy and an apparent culture prevail, in which comfort and pleasure are the principles of thought, action, and being. In not building a family home, the human person loses his identity and his dignity. He loses his paternal inheritance, as happened with the younger son in the parable of the Gospels who leaves father and brother and leaves "for a faraway country" (cf. Lk 15, 13). In the "faraway country" he falls into ideologies and searches in vain for his identity within them, all this after reducing the evil which injures man to an easily answered riddle and not stopping to stay at the side of someone, not even himself. In the void which does not call for love there dies both thought and will. In the void man perishes. The road to salvation from the appearances of life and from mortal sadness passes through the man wounded by evil. Job calls on his friends to stop and to be a gift to him—that is, to justify both his and their being. Those who stop to be beside him "will see" God with him and will experience a happiness different to all those different kinds of happiness which they have previously experienced. What happens through the *compassion* which links the Samaritan to the man wounded by evil creates the story which could save us if, as Plato would have said, "we gave faith" to that very story.[12]

The Samaritan was so open to pride, and thus free as well, that when the presence of the wounded man caught him unawares and surprised him he put up "resistance," stopped and changed his plans. The Gospels say that the Samaritan was greatly moved at the sight of the man afflicted by evil—"he was compassionate towards him." The tears of emotion purified his eyes and for this reason the Samaritan was able to perceive what neither the priest nor the Levite, and not even the friends of Job, were able to see.

The truth revealed in the other man placed the Samaritan in front of two difficult challenges. In replying to these the Samaritan gives priority to his neighbor over his affairs in Jericho. This makes the other man almost a co-owner of his property. The Samaritan is not in a hurry. He gives his time to the other person. He is able to give it because it is under his command. He measures his freedom in terms of the greatest future of time. This generous realism allows him to be master of himself and therefore enables him to exist as a gift for other individuals.

In converting himself to the wounded man the Samaritan comes to know the truth of what he is. Thinking in its deep-

est sense has the character of a dialogue. For this reason it requires action and an enlarging of hearts—or, to put it another way, love. This indeed begins in the *com-passio personarum*. The tears he sheds enables man to perceive the truth that he can only ask about. It is precisely this question which is the essence of the dialogue, and without this dialogue, indeed, man cannot think.

What does the Samaritan think? The Samaritan is profoundly moved by the human being who is in danger of dying. He is moved by the contingency of the being of the man with whom he has come into contact and who shows him a road to be taken which is different from that which leads to Jericho. And it is this other road which the Samaritan has asked for. He asked for it not with words but with a change in his own existence. He will indeed go to Jericho, but by a different route.

Through the contingency of the human being he has seen the fragile contingency of the world of things, their non-necessity. Previously the Samaritan had seen only changes in the world, changes which he could dominate, in much the same way as Oedipus answered the riddle of the sphinx which had man as its subject. But only when he is face to face with death—that descent of the being of the person into non-being—does he enter into that context where he becomes a metaphysical question about being.[13] An increased sensitivity to the contingency of the human being and metaphysical thought arise in the Samaritan thanks to his being "moved" by the presence of the man who is threatened by nonbeing. The Samaritan senses that the being of the man asks for help in order to exist. Who can give him that help? The answer to this question does not solely lie in thinking about the condition of the wounded man—something which the priest and the Levite (or the friends of Job) certainly did. The Samaritan does not search for help for the other person in thoughts—on the contrary, he begins to act. He performs actions which there at that very moment require his and not another person's presence. Taking the other man within himself, the Samaritan justifies both his own being and that of the other person. He strengthens both and defends both from nonbeing.

St. Thomas of Aquinas would probably have said that the fact of his being "moved" led the Samaritan to take the so-called third path *ex contingentia*. This path leads him to the Being who exists by His own will—that is to say God. It is the path of creative action which embraces man and the path of creative embrace which acts with man for man. Within this creative action is gradually revealed the Action of the Love of God. Because of this, the action of man becomes the image of the Action of God, and this image is ever more expressive of what it represents. In the actions of man there is something of a divine character, something which reveals itself in being present in such actions, it is something which cannot be seen or understood by man himself, it is the moment of sacrifice. Is man, for example, able to say why he goes to the aid of someone who is drowning notwithstanding the very great danger to his own life? Here can be seen the "bet" of Pascal. Act as though there were eternal Life—it will reveal itself to you and will enter into you through your actions. Where there is something to be saved grace will flow forth.

"From close at hand
It is difficult to grasp
that God is there.
But where there is danger, there
also grows that which saves you.
In the shadows live
the Eagles and without fear
go the children of the Alps
over the abyss
of weakly built bridges."
(Fr. Holderlin, *Patmos*)

In the being "moved" of the Samaritan there is that sadness which St. Thomas of Aquinas called mercy.[14] Both heroic thought and in equal fashion heroic existence, and therefore that which we call the metaphysical, spring from mercy in *com-passione personarum*. He who knows how to live knows how to think, and he who knows how to suffer with others—that is to say he who makes other people his neighbor—knows how to live. Thought is dialogue, but loneliness kills dialogue. King Oedipus begins to understand the truth about man—a truth which has nothing in common with the world of riddles—only when his daughter Antigone, in analogous fashion to the Samaritan, leads him into the lands from which one starts out.

Heroic thought and heroic existence are the essence of creative work which opens man—and here one speaks in religious terms—to resurrection[15] We should not forget that Christ told the story of the Samaritan as an answer to a question about what one should do to inherit eternal life.

It is the greatness of God which is of the essence in the life of man. It is precisely for this reason that man can only ask questions about the truth of his being. He asks about it with keenness and hope *in com-passione*[16] because only *in com-passione* does he cease calculating and thus stop fleeing from what he is in the "faraway countries" of his own inventions. *In com-passione* we think and exist with responsibility and faith. Our creative (*creatio*) actions have their outcome (*gubernatio*) in our thinking and existing with the other man and for the other man. The Samaritan treated the wounds of the poor victim; took him to an inn and "took care of him"; and entrusted him to the inn keeper and promised to return. (Lk 10:34-5) The fact that the Samaritan is moved creates a space for interpersonal relations: others enter into his work. In the Gospel parable, society is born when the inn-keeper enters into the *com-passio* which united the Samaritan with the injured man. Society is born when a third man enters into the act by which a man makes himself another man's neighbor.

Only in a space which is social in this sense and in performing a creative act which does justice to what happens in order to express truth for the mind and good for the heart, does man come to understand that his being is directed towards Another Being. In this way as well, by making himself a neighbor for others, he becomes freed of every Jericho. The free man—that is to say he who is true to the other man in creative fashion—betrays humanity and the Divine when he distances himself from Him and goes to the "faraway country" of his own private inventions. Where the word betrayal is an empty word, the word society is also empty.

The "little prince" said of the society of individuals who made themselves neighbors of each other in creative fashion: "you have golden colored hair. It will be wonderful when you take me into your home. The corn is gold and will make me think of you. And I will love the sound of the wind in the corn... Only those things which have a home can be known. Men no longer have time to know anything. They buy things already made from merchants. But because merchants in friends do not exist, men no longer have friends. If you want a friend take me into your home!"[17] A society of friends which "make a home" for each other, their mutual and shared presence which is so great that it reveals itself in all its splendor only

through their...absence such a thing transforms the world. This presence is full of joy. It distinguishes itself from empty merriment because it is rooted in sadness *com-passionis personarum*. It is the joy of contingency understood and justified by mercy. He who is a vehicle for the words *volo quod sis* (St. Augustine)—I want you to be, to be better than you are—experiences joy.

If such becomes the situation of man, then we are dealing with society in the deepest sense of the term. In such a context eros-desire, which is conceived in human Misery, are filled with Divine Abundance, by that .....,[18] and becomes a love which is given in divine fashion. Eros-desire directs man towards God[19] and becomes ever more the divine wish to be a gift for others. Plato understood this truth when he declared through the lips of Diotima that "divinity does not become mixed with man. Through Eros is expressed every relationship and every conversation between the gods and men, both when these last are asleep and when they are awake."[20] The "demoniacal man" is different from the "mere workman"—he behaves like a *pontifex*, he builds bridges between men and God, he produces in unselfish fashion and creates in Beauty.[21] In building such bridges he becomes a neighbor of the other person. He exists because he is a gift. The Gospels do not tell us what happened to the learned man of law who asked Christ about eternal life in order "to put him to the test" (Lk 10:25). It is certainly true that his attachment to the scholarship he possesses makes it more difficult for him to become somebody's neighbor. The capacity of Oedipus to solve riddles about acquired functions enables man to enter Thebes or Jericho but it makes it more difficult for him to enter eternal life (cf. Mk 10:23-25). The young rich man "went away sad at heart, for he had great possessions" (Mt 19:22). The surrogates of truth and good obstruct the way to happiness—that which is called *beatitudo*—because they weaken within man that capacity of his to receive truth and good.[22]

Christ spoke about new life to Nicodemus who did not want to put Jesus to the test but sought to know what was in his heart. Christ spoke about new life to the Samaritan who asked for such a life by asking about eternal life. The peace which flowed out from Nicodemus and the joy of the Samaritan expressed themselves to other people. Men who are so happy carry to others the truth of God about man, the truth which is present in them. They are apostles.

The joy of happiness is the fruit of the mutual presence of people. "When you look at the sky, the night, and because I will live in one of those and I will laugh in one of those, for you it will be as if all the stars were laughing."[23] The joy of happiness is the fruit of shared work. The cultivation of the soil—a task which God gave to Adam and Eve, to a community of love rather than to mere individuals (cf. *Gen* 1:28)—stops being a dimension of the creation of society and culture when it becomes closed up in the interests of individuals. The person must enter into the work of his neighbor in order to participate in joy. This, indeed, has the character of communion. (cf. *Jn* 4:38)

We cannot speak about work, culture and happiness unless we speak in religious terms and within a religious framework.[24] In this sense nothing need be added to the words of Plato: "Whoever...has cultivated love for knowledge and truthful thoughts seriously, and has engaged in these faculties above all others, is, I believe, led to think on immortal and divine questions, provided that he refers to the truth. There is no defective part within him in that long space which reaches to the points where human nature is endowed with the ability to participate in immortality. To this man who always stewards the divine and has scrupulous respect for the guiding genius who lives within him—the demon—is in special fashion guaranteed eudemonia, the happiness of life."[25]

In the parable of the prodigal son the older brother did not make himself the neighbor of his own wounded brother. In passing him by without pity in going down to his Jericho, he also wasted his inheritance. Were it not for the presence of the Father—He who never stops making himself a neighbor to all his children—in that song of our existence there would prevail a desperate sadness and an equally desperate revelry of men who draw away towards a "faraway country" where a wild injustice reigns. In the story which takes place in the presence of the Father "in the end also that which is wild must come to the sacred place of the faraway countries" (Fr. Holderlin, *Friedensfier*); a place in which *sunt lacrimae rerum* and *gaudium et spes;* a place where just mercy governs.

Professor STANISLAW GRYGIEL
Professor of Philosophical Anthropology at the John Paul II Pontifical Institute for Marriage and Family Studies, at the Pontifical Lateran University, - Rome

Notes

1. I am in no doubt that the so-called transcendental elements of classical metaphysics—being, truth and good *(ens, verum et bonum)*—if they are not reduced to a product of human thought and thereby destroyed, direct the intellect and the will of man towards God. Metaphysics has no sense if in speaking about that which becomes in order to be able to be, reference is not made to God.

2. The parable of the compassionate Samaritan shows how searching to pass from so-called enunciative sentences to imperative sentences causes a distancing from the truth of God. Moral engagement does not spring from the mechanisms of reasoning but from the presence of man for the sake of man, and this is a presence which calls men to perform acts of compassionate justice.

3. ANTOINE DE SAINT-EXUPERY, *Il Piccolo Principe* (Bompiani, Milan, 1993), p. 37.

4. It should be remembered here that Aristotle had much to say on the subject and believed that friendship "is something which is very necessary to life, Indeed, nobody would chose to live without friends, even if he has every other good" (*Ethica Nicomachea*, 1155a).

5. PLATO, *Convitus*, 203a.

6. JEAN-PAUL SARTRE, *Flies*, II, 3 and 4.

7. Cf. *Summa Theologiae*, I-IIae, 35, 8, c.

8. Cf. ST THOMAS AQUINAS, *Summa Theologiae*, I, 63,2, ad 2 *(Acedia...est quedam tristitia qua homo reditur tardus ad spirituales actus).*

9. See the classical maxim *creatio est continua gubernatio.*

10. *Ethica Eudemia*, 1234b.

11. The word "economy" comes from the greek *oikos* (home) and *nomos* (custom, law).

12. Cf. PLATO, *The Republic*, 621c.

13. From the perspective of the experience of the danger of death, we should think in new terms both about the materialistic vision of Permenides about being (of the One)—a vision in which changes are apparent—and about the pantheistic philosophy of change of Heraclitus. It seems to me that the fact that they do not consider the Samaritan's experience of the mortal danger which hangs above the being of man, means that they are unable to become a question about the Other Reality. Non-being, indeed, does not exist. Death, on the other hand, cannot be reduced to the changes observed in the world.

14. Cf. *Summa Theologiae*, I-II, 35, 8c *(Misericordia, quae est tristitia de alieno malo, inquantum aestimatur ut proprium).*

15. It seems to me that in heroic thinking and equally heroic being, the so-called third way of St Thomas Aquinas begins and takes place. It is in the profound concern for man that the contingency of our being and existing is manifested.

16. Cf STANISLAW GRYGIEL, "Il Senso della Sofferenza nel Mondo Secolarizzato," in *Il Nuovo Aeropago*, no. 2/1995.

17. Cf *Ibid.*, p. 93ff.

18. ARISTOTLE, *Metaphysics*, A, 1072b.

19. CF. PLATO, *Convitus*, 178c,d,

20. *Ibid.*, 203a.

21. *Ibid.*, 206d,e.

22. The Latin word *beatitud* comes from *beatus* which refers to a person who has received good, *bonum*.

23. *Il Piccolo Principe*, p. 116.

24. The words *cultus* and "culture" derive from the word *colo*, that is "cultivated." Only by working in a communal fashion can we "till the land." The same is true of free individuals, that is to say individuals linked to the truth and the good which come from God. We work, therefore, for man, and worship God in the truth and in the good of what is.

25. PLATO, *Timeus*, 90b,c.

WANDA POLTAWSKA

The Responsibility of the Medical Doctor and the Life of the Patient

Introduction

The medical profession has been the object of esteem and respect for many centuries. Some have called it a free profession, others have seen it as a vocation. It has even been suggested that it is not a profession at all but an art—*ars medica*.

This "calling" is completely directed towards the good of other people and has always involved a special responsibility. This has been apparent in the creation of an independent set of professional ethics from the times of Hippocrates, a code which has been accepted by doctors all over the world. This medical code applied to the practice of medicine justifies the trust which people place in medical doctors. This general esteem is a response to the special character of this profession—a profession which is indeed worthy of respect.

In this way a special dependence of the patient on the doctor has arisen. This dependence still exists even if the general attitude towards medical doctors is not always infused with esteem and admiration. In recent decades, indeed, the ethos of doctors has undergone such great changes that it has become necessary to define what the true characteristics of this ethos really are. This, in turn, has given rise to an urgent need to achieve a precise and renewed definition of the duties and the rights of medical doctors.

1. The Traditional Ethics of Medical Doctors and Catholic Ethics

The traditional ethical code of Hippocrates did not in any way find itself in opposition to Catholic ethics. For centuries Catholics have not encountered any difficulty when taking the oath asked of them. Only actual changes introduced into the text of the oath have caused conflict and radical friction. Under the totalitarian regimes doctors were often the executors of a variety of political tasks and for this reason such regimes tried to control and direct their professional activities, a process which involved depriving medical doctors of their professional independence.

The activities of German doctors at the time of Hitler was an example of such a state of affairs and culminated in the infamous death penalties imposed upon many doctors after the Nuremberg trials. Indeed, in 1947 the Supreme Court of Nuremberg returned independence to medicine by establishing in firm and decisive fashion that the medical doctor should only follow his conscience as a doctor and the guidelines of traditional professional ethics, and should not be forced to accept and follow laws decreed by other institutions. The medical doctor, therefore, is authorized to go against requests which are contrary to his professional conscience.

It might appear that a statement of this kind acted to save the ethos of the profession from various dangers. It might seem, that is to say, that from the Nuremberg trials onwards the situation in the field of world medicine has changed decisively. The opposite is the truth. Crimes which were clearly judged at Nuremberg to be "crimes" have since acquired social acceptance. I am referring here to killing sick people in order to shorten a useless life or the use of people to carry out experiments. Indeed, at the present time many doctors engage in activity which would have been condemned as criminal at the Nuremberg trials.

This highly significant transformation in professional ethics has created a fundamental problem for Catholic doctors. Indeed, it rightly gives rise to difficulties because there is a fundamental conflict between present-day medical practice and the principles of Catholic ethics—those ethics which the Catholic doctor is called upon to practice in the exercise of his profession. In the same way, the patient who is a believer also has the right to expect that the doctor behaves and gives advice in line with the canons of the Hippocratic oath. Such a situation creates an inevitable dichotomy within the world's medical profession, as indeed is more than demonstrated by the frequent establishment of specific separate organizations for Catholic doctors.

The traditional ethical code of Hippocrates obliged doctors to follow certain fundamental points which are binding upon every honest doctor still today, and they are above and independent of his particular way of seeing the world:

a) *Primum non nocere—Above all else, do no evil.*

This principle requires constant study and updating to ensure an exact diagnosis of the pathology which is present. Where doubt arises, it requires the doctor to call upon colleagues who have greater expertise and experience. It might be pointed out that the traditional second opinion is disappearing and each doctor now sees himself as an "authority." This principle also requires constant study and research to find new and more effective methods of treatment. But at the same time it requires prudence and long-term reflection. That is to say it calls for prudence in the hurried acceptance of what is new—it can often happen that the forms of treatment which are proposed have worse consequences for the patient

than the illness itself. The most important thing is to pay primary attention to the immunity systems of the body and if possible strengthen them. Overall, this principle imposes a certain humility on the physician.

b) *Salus aegroti suprema lex est*

The need to place the health of the patient first in the exercise of the profession of medicine has given rise to the building of an ever larger number of hospitals and rest homes in order to be able to treat the sick person in the ways and with the time which are required.

But for the medical doctor who is a believer the concept of health has to include something more than the mere health of the body. In the Christian mental framework, man is never a body alone: he is a person who has his origins in God; he has a soul; and thus within him he bears a dimension of eternity to which he is directed—he is thus called to eternal happiness. According to this conception of man, the idea of *salus* must also include reference to the overall perspective of human destiny. Because of this neither therapy nor its effects can be contrary to human dignity and its responsibilities. The Catholic doctor cannot practice a form of treatment which involves, for example, the need to deprive another person of his life—as occurs in the case of surgical treatment for Alzheimer's disease and with other diseases which involve transplants.

Here we touch upon the fundamental difference between the behavior of doctors who are believers and those who are not believers, and this is a division which is becoming ever deeper. A Catholic cannot prescribe contraceptives or abortion-inducing drugs, and he cannot consent to sterilization, genetic engineering, and so forth. Sterility treatment cannot take place through the use of artificial insemination—something which is not worthy of man—nor can the treatment of sexual neurosis involve proposals to commit adultery, and all the rest.

If concern for the health of the patient (which is the basic principle of the doctor's whole activity—*suprema lex*) must consider not only the earthly life but also the supernatural life of the patient, it naturally follows that the advice given by the doctor cannot damage the soul. Indeed, the advice of the doctor must accept the primary importance of the soul in relation to the body and must take the destiny of that soul into account.

For this reason, if a newborn child has uncertain health or his life is in danger, the Catholic doctor must make sure that the child is baptized immediately. In the same way, if a patient is seriously ill he must have the opportunity of having absolution and the last rites.

All advice given by the doctor regarding both treatment and prevention must take an exact and overall vision of man into account. To this end, the doctor must not only know but

also accept the principles of Christian anthropology and always be in line and concordance with them.

2. The Correct Conception of Man in Christian Anthropology, Biologism, and Utilitarianism

The doctor can treat the patient in the right way only when he accepts the fundamental conception of man revealed by Christ himself who went "against the tide" as regards the conception of the world which prevailed when he was alive. This approach also goes against the tide when we consider the ideas which are ascendant in today's world. Before drawing near to a patient the doctor must know who he is. Christian ethics, those ethics which are the most rigorous, require that the doctor sees in the person who has been placed in his hands...God himself. These ethics call upon the doctor not to dominate the patient but to serve him. They demand the respect due to the simple fact that the patient is a man—for a Christian, to be a "man" means to be a child of God, created in the image of God himself.

The Catholic doctor must accept the divine origins of man—each and every man—quite irrespective of the condition and development of his body. In each person he must see that fundamental value which is the dignity of the human person. This person is called to the life of the Spirit, and it is at this point that Catholic ethics are totally and completely opposed to biologism which sees in man a mere collection of cells derived from the mother and father and thus ignores the Spirit which gives and maintains life. The doctor must accept the fact that the true giver of life is not the parents—they merely transmit the life received from God the Creator. As a result, only the Creator can be seen as the Lord of life; to Him alone is to be given the decision as to the moment of birth and of death. Respect for the person must lead to respect for the human body and to true canons of behavior. The right to life is the primary right of every man and the doctor must defend and promote every life—in particular lives which are threatened, weak or ill. It is obvious that the doctor does not have the right to kill an unborn child or an elderly person whose life is about to finish. A Catholic can never, in any situation, take life away from a human being.

In dubio mitius—in doubt choose the most moderate solution. This rule of behavior for the medical doctor—and especially for the specialist—notwithstanding original intentions, can end up by favoring a choice which is wrong—that is to say an acceptance of the so-called lesser evil! But the Catholic doctor can never choose evil, whatever form it may take. He cannot choose either a greater evil or a lesser evil. The choice of evil is always a sin.

The words of Jesus are very significant here: "Woe to the world, for the hurt done to consciences! It must needs be that such hurt should come, but woe to the man who through whom it comes!" (*Mt* 18:7).

Now, given that correct decisions depend upon the personal convictions of the doctor, who the doctor is and how he lives his life is not of no

importance. Christian anthropology places human life within the context of eternity and imposes decisive requirements. Man has not only received his life as a gift, he also has tasks which are linked to that gift__that is, he must be perfect "as your Heavenly Father is perfect" (*Mt* 5:48). The doctor, therefore, must be holy because this is the primary task of the life of each and every person, and of this the Catholic must be fully aware. In this way, apart from his duties towards the patient, the doctor also has precise duties towards himself. One can thus state with confidence that the first element is conditioned by the second. Of relevance here is the advice given by a doctor on television about how to conduct one's sexual life—he himself had had four wives.

Finally, the fundamental principle which governs the actions of a Christian must always be love for his neighbor, and this must be a total love. "Love your neighbor as yourselves," declare the Gospels. It is not possible to think that such love can be achieved when it is conditioned by the economic advantages which might be gained from it. Indeed, an attitude of total independence must always be adopted towards such material reward. In the history of humanity there have been many exceptional doctors whose actions have been rooted in a love for their fellow-men—a love carried to levels of heroism. One might refer here to the Polish doctors who decided to die with their patients at the time of the Nazi persecution (Dr. Zdzislaw Jaroszewski)[1].

But love for one's neighbor must also be shown in the respect that one has for the body of each and every man, in the respect and delicacy with which it is treated. Indeed, given that the dignity of the human person also includes his body, the patient has the right to be treated in such a way that his dignity is neither wounded nor humiliated. An example of this is the idea that it is always necessary for the patient to undress in a way which does not take his modesty into account. For example, in radiology it is not true that the patient must undress. In American private clinics such an idea is unthinkable. The radiological examination, in actual fact, is carried out with the patient covered by a cloak—the material of the garment does not cause shades on the X ray.

To conclude, the doctor is often present at the moment of death. For the believer death is an encounter with God "face to face," and man must prepare himself for this moment with the utmost seriousness. As a result, the patient must not be thrown in a corridor and hidden behind a screen, left as though he were some useless thing. The Catholic doctor has the duty when present at the patient's death to pray for that patient; to prepare his family for this moment with all delicacy possible; and even to ensure that the family is there so that the death of the patient becomes truly human.

The Catholic doctor must make sure that in the rooms of the sick people there is a cross on the wall and a priest to help the patients. In this way a hiatus will not be created between the theory and the practice of his ethos.

3. Casuistry

When one observes the actions of doctors who describe themselves as being Catholic one can see a divergence between the statement that they belong to the Church and have received the sacraments of baptism, first communion and marriage on the one hand, and their actual behavior in the professional sphere on the other.

The medical world is simply corrupt and of this all doctors are guilty, including Catholic doctors. One need only remember what happened on the thirteenth of December in Poland when despite the fact that the representatives of the Union of Doctors were present, the Catholics voted against the principles of true ethics. The Catholic doctors are characterized by weakness and a readiness to compromise, and by their easy subjection to the pressures of the medical world to obtain profits and popularity. One could cite endless examples of moral degradation in the medical field, not to allocate blame but to provoke initiatives which will improve this situation.

One way of doing this is through pastoral work in the health sphere. This has been done by the Catholic Church, for example, in Krakow, where there is a special tradition—a tradition promoted by the Holy Father who was responsible for such pastoral work in that city.

Indeed, the Church is concerned with the salvation of man and gives precise indications. But a knowledge of the publications and directives of the Church in this area is very weak amongst doctors, even though many papal communications dwell upon questions that doctors deal with or with which they should be concerned.

For this reason the first task of a Catholic doctor is to have a profound knowledge of the doctrine of the Church and to see how his own ideas relate to the principles of Catholic ethics. He should not only be aware of general rules but be informed as to how they should be applied in the practical situations which actually arise.

At the present time there is an enormous temptation to follow progressive and liberal currents. This is a temptation which derives from human vanity alone. But the medical doctor should become the instrument of divine grace rather than arrogate to himself those rights which in fact belong to the Creator. Thus it is not for the doctor to decide the moment of birth or to decree who should have a child or when a grandmother should be killed.

Test-tube fertilization is another temptation which afflicts the medical world in the name of so-called "scientific progress." This is certainly a development with regard to technological possibilities, but in relation to human dignity this way of being born is in opposition to the essence of that dignity. It is something fit for animals, creatures quite different from man. Although one cannot deny that

one should treat infertility, it is necessary to place clear limits to what science should do.

The Catholic doctor

1) must never, in any circumstances, kill a child. There is no medical diagnosis in the world which authorizes a doctor to kill. There can only be special forms of treatment when the pregnancy involves complications, because in such a situation there is always the question of saving two individuals;

2) may never propose or carry out artificial fertilization "in vivo" or "in vetro," quite apart from the fact of whether such fertilization is homologous or heterologous;

3) may never invite the patient to secure artificial ejaculation for the purposes of examining the quantity of spermatazoa, not least because the results of such a test are never certain. Indeed, there are people who have five children despite the fact that a sperm analysis demonstrates a low count in both quantitative and qualitative terms;

4) does not have to carry out a prenatal diagnosis in all cases, and such diagnoses, when carried out, must be used for possible treatment, never to kill;

5) must never suggest to a person afflicted by AIDS, or to people with other kinds of sexually transmitted diseases, that a condom be used. This is because abstinence alone is a safe and effective form of prevention;

6) must make clear in decisive fashion that virginity is not in contradiction to nature and must promote an authentic vision of human sexuality. There is no physiological mechanism which forces an individual to engage in sexual activity;

7) must never advise divorce as a solution to a situation of conflict when there are contrasts within the marriage relationship;

8) can never allow his professional service to be influenced or conditioned by the economic advantages which he gains or might gain from such service;

9) does not have the right to kill a seriously ill person, giving as an excuse the motivation of so-called "mercy." Nobody knows the extent to which the difficult moments of the illness may be necessary to salvation;

10) can never succumb to pressure of any kind whatsoever, but must always be guided by the Catholic ethical code, and this also applies to cases where this involves economic loss or even loss of prestige for the doctor;

11) must always give a clear and decisive opinion in relation to the ever controversial question of contraceptives, and if he does not understand the reasons for this policy he must seek the advice of a moral expert or read the publications on the subject issued by the Church;

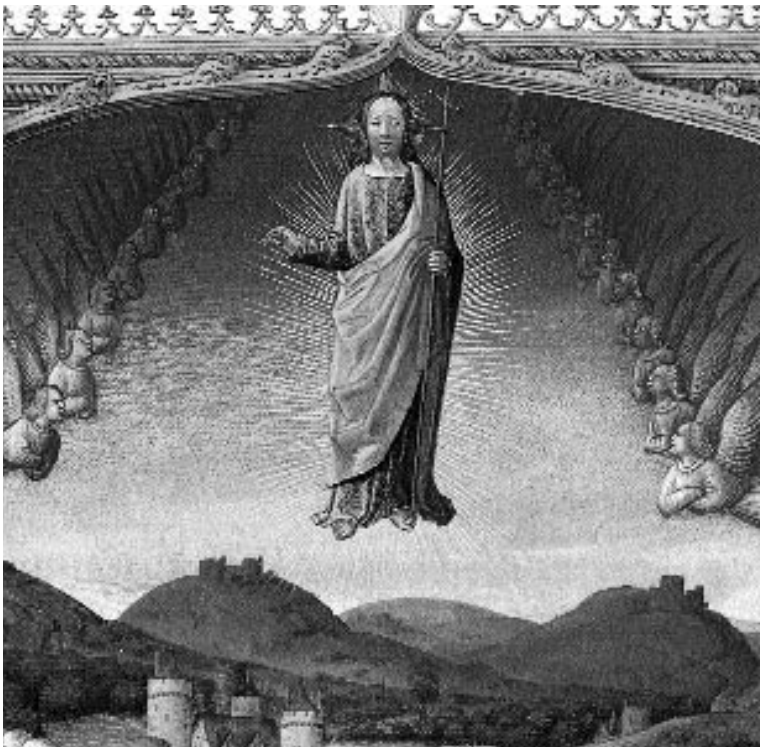
12) in his own life must take advantage of the grace of the sacraments so that the advice he gives is illuminated by the Holy Spirit. The Catholic doctor should be aware that his actions should be in harmony with those words addressed by the Holy Father to doctors when the Pope was in Krakow: "You are my hand stretched out to those who do not come to me."

"Let your word be Yes for Yes, and No for No" (*Mt* 5:37)— without ambiguity.

Professor WANDA POLTAWSKA
Member of the Pontifical Academy for Life, Director of the Institute for the Theology of the Family at the Pontifical Theological Academy in Krakow, Poland, Consultor to the Pontifical Council for Pastoral Assistance to Health Care Workers

Notes

[1.] *Sterminio dei Malati di Mente in Polonia 1939-1945* (PWN, Warsaw, 1993).



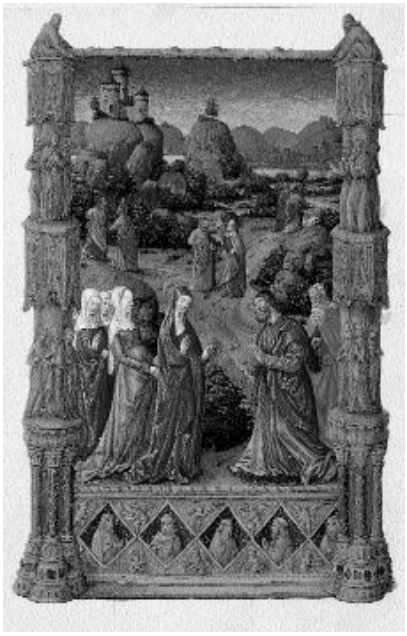
ELIO SGRECCIA

The Embryo: A Sign of Contradiction

First of all, I would like to express my deep gratitude to His Eminence Cardinal Angelini for inviting me to open the debate of this round table. At the same time I would like to express my admiration and good wishes for the success which these international conferences have always enjoyed and achieved—conferences which are a point of reference, among many other things, for ethical-medical reflection, thought, and written discussion. I greet the authorities and experts who are present and I especially thank those who will make a contribution to the debate which will be conducted by this round table. The subject which we are to discuss this afternoon at this round table has become of central importance to the present-day debate which revolves around two principal areas: bioethics and biolaw.

We need only look at the data bank of bioethical and medical writing on the subject to see how this is so. In the years 1970-1974 rather more than five hundred works dealing with the biomedical aspect of the question existed, and there were twenty-seven works of a philosophical-theological character. In the years 1990-1994 there were nearly 4,200 works on the biomedical dimension of the subject and 242 on the philosophical-theological aspect of the debate. The reasons for this are more than evident, and we are not dealing here, as before, with the mere question of abortion, however present, painful and controversial that topic may be.

The subject of abortion has indeed been of major public interest. There was, for example, the special commission of the American Senate which met on 23 April 1981, a commission established by President Reagan and to which Professor Lejeune gave evidence. There have also been a large number of legislative proposals aimed at making abortion lawful in such Latin American countries as Peru and Mexico. These proposals have necessarily involved the question of the status of the embryo and the fetus, either directly or indirectly, if only because the life of the



fetus and that of the mother have been considered in relation to each other. But at the present day there are two other great questions which have brought bioethics and biolaw to the center of public attention:

a) the question of in vitro procreation which involves the phenomenon of the surplus production of embryos which come to be termed "supernumerary" (a new category of human being) and where a number of abuses take place: freezing, transfers which cause death, experiments, periodic destruction ordered by governments, and the removal of cells;

b) the question of new products, methods and vaccines which are deemed contraceptive, interceptive or anti-pregnancy but which are in reality techniques of abortion because they prevent the implanting or the process of implanting of an ovule which has already been fertilized. Amongst these, reference should be made to the IUD, the day-after pill, the northplant, and vaccines. *Evangelium Vitae* deals with this whole area at n. 13. It is in relation to these questions, and above all in relation to in vitro procreation, that the highly sophisticated and groundless theories of the pre-embryo (the early embryo of the first fifteen days of life) or the pro-embryo (the embryo of the first eight days of life) have sprung up. The basic biological and philosophical dimensions of these ideas and theories will, I imagine, be examined by those who are to contribute to this round table.

I would like here to draw attention to a quotation from one of the Fathers of the Church, Tertullian: *"homo est qui venturus est."*

I would like to draw even greater attention to a passage from the instruction *Donum Vitae* which is in turn quoted by the encyclical *Evangelium Vitae:* "From the moment when the ovule is fertilized a life begins which is not that of the father or of the mother but of a new human being which develops of its own accord. It can never be human if it is not human from that moment... At the moment of fertilization is begun the adventure of human life, and each of the great capacities of this life needs time to find its balance and to prepare itself to act." (*Donum Vitae,* I,1; *Evangelium Vitae*, no. 60).

The proof of this statement is to be

found above all else in biological facts:

1. From the moment of fertilization we are in the presence of a *new, independent, individualized* being which develops in *continuous* fashion. There is no moment which is less necessary than another (and this is even recognized in the Warnock Report), and each stage is strictly dependent upon the stage which precedes it and which determines it.

2. Objections based upon the fact of gemination, upon the appearance of the primitive streak and of the nervous system bud, and upon the relevance of the implanting as a decisive event for the continuation of development, do not bear in the least upon the individuality of the embryo or the continuity of development: in the process of didymous separation the residual part does not lose the individuality of being human and the new part which separates off has its own new individuality; the appearance of the primitive streak and of the nervous system—like the whole process of organogenesis—are the outcome of this active and individualized development.

The two moments of real discontinuity in the life of an individual are to be found in the acts of fertilization and of death. Leaving this reality apart, human and philosophical reason must go beyond functionalist or phenomenologist forms of mentality which approach facts in relation to their operative capacities and with reference to the demonstration of such capacities. Human reason—if, that is, it really seeks explanations and gives explanations for facts—cannot but affirm that authentic explanation which is given to us by the recognition of the existence of a special and specific energy which informs and animates the whole of the human being; which vitalizes it and individualizes it. This is none other than a self capable of spirituality, a personal self, which bears within itself all that active capacity which fulfills and realizes itself in the person.

R. Colombo, a molecular biologist, observes: "None of the scientific knowledge available to us allows certain support for the objections raised to the rational nature of the human embryo and the human fetus and its individualization."

In order to investigate this subject the Academy for Life has set up a multidisciplinary task force which will study all the aspects of the whole question and then publish a work on the subject.

It is in order to discuss this overall subject and to defend the position taken by the encyclical publication *Evangelium Vitae* that I must now (with little elegance) withdraw to take part in the special work group of the National Committee for Bioethics which is now discussing this same question. I will now invite the first speaker to address the conference, and I offer my apologies to everyone here present.

Most Rev. ELIO SGRECCIA
Vice President of the Pontifical Council for Life, Secretary of the Pontifical Council for the Family

MARIE-ODILE RETHORÉ

Jérôme Lejeune: A Scientific and Christian Profile

When in 1952 Mr. Lejeune asked me (having been advised to do so by his wife) to work with him "on genetics" I accepted immediately. However, I had absolutely no idea about what awaited me. At that time genetics was not taught in medical faculties.

Jérôme Lejeune at that time worked in the pediatrics section led by Professor Raymond Turpin. It was there that he discovered children which were called "mongoloid" and to whom he would dedicate a great part of his existence.

Professor Turpin was the only person at that time to have created a clinic for children suffering from a mental handicap. Mr. Lejeune often said that such a handicap was "undoubtedly the most dramatic because only man can suffer from it and it is the most inhuman because it prevents the patient from being fully himself."

After becoming a researcher he did everything in his power to set up a research laboratory: "a sort of machine with which to seize the opportunity presented to me, whose effectiveness depended upon a condition of permanent alertness."

A little more than ten years later, on 10 March 1965, during an inaugural lesson, Professor Lejeune recalled the establishment of that research laboratory with a certain nostalgia and a great deal of emotion: "The place was very beautiful. It had two great sky-lights but there was neither water nor gas nor any kind of support plan. Our microscope, which had been the pride of the hospital during the twenties, was still of a certain use especially when the filed teeth of its cogs were covered with a piece of chocolate paper carefully placed in its gears."[1]

From that time we have acquired a large number of new and advanced machines which have become ever more effective and sophisticated. I have not seen one which from an early stage was not transformed, I would even say transfigured, with jam or chocolate paper, or with transparent tape. All the salesman and people who installed these machines went away amazed and astounded, but never convinced by the effectiveness of the transformation in the workings of these machines which we had achieved.

But let us return to the initial description of the laboratory and of its microscope. "This wonderful lens lay on a trolley for sick people which acted as a solid support. A high chair was a part of the support, that kind of chair which is rather like those that one still sees today behind an old organ in a church. This was where the trolley was so useful. Instead of moving the chair—a risky undertaking given its age—one sat down immediately with a complete sense of security.

And just like Grok with his piano, we found it was merely necessary to draw the trolley forwards to see everything with great ease. This was really a lucky find and it brought us great advantages." I would add: here we see how easy it is to be a happy man—he needed nothing else!

He loved his work. He believed in it deeply and it was this, I

I never saw bitterness, jealousy or envy in him. Yes, indeed! He was happy in a simple fashion and knew how to make other people happy.

He was ready with a joke at every moment. He played with words and could not do otherwise. This disoriented his detractors, even the most choreic! He often asked me to read what he had just written. When I found a play on words which was overdone I said to him simply: "What you have written here you like but perhaps you could cut it out." He then said to me "It would be a pity, but no doubt you are right," and he conceded the point.

When hurt by criticism which came from all directions or he was worried about what would happen to the institution he used to say to me: "Why worry, why lose time over things over which one has no control." Perhaps he knew that his days were counted. When it was necessary to separate him from his work at times one had the sensation that one was doing something wrong. During his illness I heard just one complaint: "It's so so stupid. There are so many things still to do."

He was not worried; he was not afraid. A journalist asked him if he was afraid of the capacity of technology to blow up our planet and he replied: "I am in favor of absolute trust, for the very simple reason that I think man is immortal. I believe that man is made for eternity but I am not sure that humanity is made for eternity. The real question is to know if man is or is not made in the image of God. If God has or has not loved man so much as to give him his image. If the answer is yes, then humanity acquires a clear and high dignity. But if you think that man is a matter of mere chance, the product of accident in an indifferent universe, why should one not indeed continue to play fast and loose with mankind?"[2]

"My father was an admirable guide, and to him I owe everything I know which is of real importance. He taught me that the existence of a man must be ruled by two imperatives: rectitude in judgment and enthusiasm

for what is true. My mother taught me the greatness of devotion and the power of goodness." Here we can see the roots of the guiding thread of this man of research, this doctor, and this teacher.

"Research should be carried out with one's whole heart, for all of one's life, and all the time, otherwise it is not research! Researchers do not know more than other people. They are by no means wiser in the static sense of the term. They are only men of learning whose passion for understanding has not obscured their faculty to admire. This enthusiasm for nature is the only real sign of the researcher."[3]

His propensity to imagine general theories never led him to forget the primary importance of experimental steps: "During the course which I will have the honor to present you with," he used to say to his students at the inaugural lesson, "everything which I will explain to you as being experimentally proved must be accepted by you as constituting building blocks of good quality. But everything which I will suggest to you which is an explanatory hypothesis you will have to consider as being provisional scaffolding which perhaps masks the final architecture of a building which is still at the building site stage."[4]

The medical doctor at the service of patients always came before the researcher. "You only need to know the terrible experience of a soul imprisoned within an imperfect body, of an intelligence which feels itself but which cannot express itself because of the lack of a finite substratum, to understand that medicine must not surrender to this sentence pronounced by destiny, that we must not resign ourselves to the irreparable. The whole history of medicine teaches us that those who have freed man from the plague and from rabies are not those who suffocated those afflicted with rabies between two cushions or who burnt the houses of those struck down by the plague. The morality of medicine can be expressed in a single phrase: hatred for the illness, love for the patient. If this is forgotten, we are perhaps technicians but we are most certainly not medical doctors."[5]

In order to have a better understanding of the connection between genetic disturbance and its pathological consequences, and above all else to tackle the need for a therapeutic solution which could be presented to his patients, he became a researcher in the field of biochemistry: "it is a question of life or death" he often said to me, "if we do not cure them they will be killed." He suggested a variety of theoretical models which would permit a representation of the sensitive surface of cerebral cells and thus involve the prediction of the types of molecules which could be acted upon in this kind of metabo-

lism so as to achieve a reduction in the disturbance. "Men are not born equal before destiny. The only dignity which exists in our science is the search for means by which to restore to men by means which are as different as they are necessary that which nature has refused to them or has taken from them."[6]

Everything which affected man and his intelligence was almost sacred in the eyes of Lejeune: "The new moralists argue that man is made by society, that it is society which gives him intelligence and that as a result society has the right to dispose of him with the laws it creates for itself. However, the knowledge which we have accumulated over the centuries tells us that the opposite is true. Human intelligence and the whole of science are not the products of evolution in the automatic sense of the term: the intelligence of men exists because they are made in that way! It has been given to them entirely and freely!"[7]

He compared the working of modern computers to human intelligence and made the following observations: "they resemble each other merely because the calculators are made by men and it is not surprising that we find in their highest examples a kind of mirror in which we configure." But he immediately went on to declare: "this means that computers are in precise terms disembodied intelligence. It is for this reason that at times their powers seem so much to be feared. Men are exactly the opposite. They are in a precise way an incarnation of intelligence, and it is for this reason that each one of us is so valuable."[8]

"A commonly held opinion regards man as an anomaly without a cause whose destiny is nowhere inscribed, an object which will be forever incomprehensible, the fortuitous product of an indifferent universe. Either human intelligence is the outcome of chance—the mere expression of evolutionary mechanisms as some people would have it—and thus according to the ancient aphorism of Democrates (expressed in new form by Monod) a question of where "everything in nature is the outcome of chance and necessity," or our intelligence is (as Engels would have it) the mere consequence of psycho-chemical laws. Matter and energy, it is argued, generate the spirit so that this latter appears, one day, in some corner of the universe. Leaving aside this dilemma, there is however an explanation which is more convincing.

This is that the spirit which leads the universe and its laws has created in a most special way the only living creature which is able to discover the marvels of that universe. In such a line of thought the fact that the universe is intelligible itself becomes intelligible!

The absolute superiority of man, his complete newness, lies in his being the only creature able to experience a kind of link between the laws of nature and his sense of existence. The ability to admire is present only in man!

The man who was the first to know how to die and to build tombs; the

man who helped his fellow man when wounded, tended to him, fed him, and defended his weakness; the man who discovered art rather than mere techniques; that man is us, we are not more than one hundred thousand years old, and intelligent love is like a spark within us."[9]

And this man, merely because he is man, has the right to absolute respect for his life from the very first instant until his natural end. Here is one of the messages of Professor Lejeune which everybody remembers: "Some scientists express very nebulous opinions to make people believe that they—the scientists—no longer know what a human being is and that they do not know when that human being begins. But we know exactly what a human being is and we have an extremely simple definition: he is a member of our species. If the embryo were not a member of our species from the very first moments then he could never be a member of our species."[10]

A journalist asked him what he thought of ethical committees which make decisions about respect for life and about embryos, and he answered: "When I hear people talking about ethics, I am immediately careful. The people who talk about ethics often want to put morality to one side. The person who speaks about morality understands that convention should conform to higher laws, but the person who speaks about ethics assumes that laws should conform to convention."[11]

He spoke very rarely about his faith. He lived it, in simple fashion: "I have been asked what I would be if I were not a Christian. I am forced to say that I do not know. In the same way I have been asked what I would be if a were not a medical doctor. Here also I am forced to say that I do not know. It is certainly true that we have different features, but in essential terms we are all hewn from the same rock."[12]

When he was asked if as a doctor he in some way blamed God for all the suffering he came into contact with every day, he used to answer: "When faced with unbearable evil the doctor never accuses God.... The temptation to accuse God.... No, that really does not befall me."

He found the answer to the mystery of suffering in the explanation offered by Christ to the man born blind from birth: "In a similar way we can say that when men are able to overcome an illness, to save a child from death, when they ensure the advance of science, in such cases the work of God is also expressed."[13]

"In this materialistic age of ours," he said at Notre Dame in Paris on 10 October 1982,[14] "it might seem inappropriate to reconcile the facts of revelation with hypotheses based upon scientific observation. These two forms of knowledge are profoundly different. One is given freely and is

expressed in poetic language which the heart understands with joy. The other is gained with hard work and is a difficult matter which reason can only conquer with a great effort." He concluded: "Such is the decision of God, who made the sky and the earth and made all these things obscure to the wise and the knowing but revealed them to children."

At the end of his inaugural lesson he expressed his deep conviction:[15]

"Whatever the name it receives, whatever the characteristics and properties which it is attributed, or the structure which it is thought to have, something must exist at the boundaries of matter and form which transcends both but at the same time unites them. Formative virus, inner form and the coding of macromolecules are nothing but the progressive transformations of an idea which is always the same: an idea which seems inevitable to us perhaps because it is really inscribed in the deepest part of ourselves. An idea which I could not express better than by paraphrasing the beginning of an old book: at the beginning was the message. This message is in life and this message is life."

Professor MARIE-ODILE RETHORÉ
Member of the National Academy of Medicine of France,
Associate Professor of Genetics,
The University of Paris, France

Notes

1. Inaugural lesson, 10.3.1965, *L'Expansion Scientifique Française* (15, Rue Saint Benoît, Paris 75006).
2. "I do not like Speaking about Ethics When Morality is the Subject," 1.03.1985, *France Catholique*, n. 1993.
3. Inaugural lesson, 10.3.1965, *L'Expansion Scientifique Française*, (15, Rue Saint Benoît, Paris 75006).
4. Idem.
5. Idem.
6. "I do not like Speaking about Ethics When Morality is the Subject," 1.03.1985, *France Catholique*, n. 1993.
7. "The Incarnation of Intelligence," 28.09.1978, Congress of the Association of Saint Benoist, Avignon (France), *Eaux Vive*, n. 39, pp. 26-27.
8. Idem.
9. Idem.
10. Idem.
11. "I do not like Speaking about Ethics When Morality is the Subject," 1.03.1985, *France Catholique*, no. 1993.
12. Idem.
13. Idem.
14. "Biologie, Conscience et Foi," 10.10.1982, *Recherches et Expériences Spirituelles* (Notre Dame de Paris, France).
15. Inaugural lesson, 10.3.1965, *L'Expansion Scientifique Française* (15, Rue Saint Benoît, Paris 75006).

ADRIANO BAUSOLA

The Cultural Anthropology of the Right to Life

The cultural-anthropological approach to the whole question of life, its value, and its defense can take place at a number of levels.

Cultural anthropology in the strictest sense of the term is a descriptive and comparative inquiry into the various systems (or subsystems) of culture of the various ethnic communities. This involves especial attention being paid to the origins of their forms and an interpretive, but not an evaluative, system of analysis (at least at the level of declared intention because in actual fact things often turn out rather differently). This generally leads to a comparison of the various cultural systems which exist in the world.

It is, however, clearly impossible to effect a complete survey of all the cultural systems in the world, whatever the particular elements within these systems may be that one wants to investigate.

For this reason we have to choose. And I, following the orientations of my own specific cultural background, will dwell upon the subject which forms the subject of this important conference (the value and the defense of life) with reference to the Western cultural systems of our time. I will compare and contrast them and engage in a discussion about their various principal features.

An analysis of the subject of the right to life with reference to the threat to life provided by abortion is very difficult. The same may be said of the question of euthanasia as it arises within our Western societies. If there is enough time I will thus also try to engage in a brief discussion of this second question.

I will begin with a matter of fact. The debate about abortion and euthanasia centers first and foremost on the direct question of its acceptability and whether it should be recognized and sanctioned by the law.

This debate involves arguments proposed by the critics of euthanasia and abortion which should inspire general agreement because of their intrinsic worth. And yet it is a common feature of our days that these arguments are heard with difficulty: they are very often misunderstood or even rejected out of hand.

The dominant culture even derides them. Any effective anti-abortion initiative at the level of arguments and persuasion would have to take notice of the weak hold that these arguments have on our contemporaries (at least in Italy). We must ask ourselves, if we want to take effective action, what the reasons are for the failure of this persuasion however valid its principles may be—something, however, which is by no means difficult.

A historical-cultural investigation into the origins of the abortion phenomenon—a movement which is very widespread today especially within the mass media—is thus very clearly called for.

I will begin my attempt at a general path of inquiry by citing an incisive observation made by Luigi Lombardi Vallauri. For this authority, the form of the abortion phenomenon which prevails today is of a "libertarian" (abortion is legitimate because the foetus is the property of the woman, something which is hers, and anyway the woman has the right to deal with her body as she sees fit without reference to the action of the state or other authorities) rather than a "humanitarian" (abortion is a "lesser evil" to be prevented where possible but tolerated otherwise) character. We should therefore analyze the characteristics of the doctrine of libertarian the abortion phenomenon: the egalitarian-homosexual tendency which goes with certain defenses of abortion, especially in the feminist camp; anti-Catholicism, anarchism and other elements.

When this has been done the question poses itself: how did we come to all this? To employ Freudian terminology, we can see how Christian ethics—ethics which, among other things, involve duty, sacrifice, the overcoming of mere personal interest and thus are capable of safeguarding every life even when that life cannot make itself felt—had far less difficulties in the pre-industrial scientific-social pre-modern age than in today's world. The "principle of reality" in such a context called on people to make sacrifices (given the fact that the resources available at that time were rather limited) and gave credence to the outlook of Christian ethics with their ideas about moderation and self-restraint. This made people ready to accept rules which required the sacrificing of personal interests in order to defend the rights of others, including the rights of those who were not yet born.

With the emergence of industrial society, and the triumph of technology, it appeared that the availability of goods had become so extensive that the idea of self-sacrifice which was characteristic of previous ages was no longer necessary. Not so long ago the idea became widely accepted in industrialized societies that poverty was by now a thing of the past and that "the principle of reality" no longer required traditional inhibitions.

As Augusto del Noce has written, "The total dominion of man over nature seems to have coincided with the disappearance of ethics, at least in relation to sacrifice, self-restraint and asceticism. The disappearance of religion and morality seems to have been a part of the victory of technology. Technological progress thus appears to have made a complete naturalism possible."

Here we can see that what was previously only argued by certain philosophers became widespread at a mass level: "the principle of pleasure" became the criterion for human action, and ethical libertarianism became the formula which most suitably expressed it. I would observe that at the root of this process was the historical crisis (not a real crisis given that in truth things are very different) of the metaphysical (and Christian) belief which held that the world was full of objective meaning, and that this was because it was given a purpose by God. In such a way the world was in itself oriented and oriented man according to certain objective moral norms. The atheism and materialism of certain modern philosophies have given theoretical expression to, and universalized, the mechanistic conception of the universe which has been characteristic of modern science from its birth onwards. It should be remembered here that science itself, during the course of this century, has often greatly changed its own principles and has raised new questions about the real existence of this mechanism.

Materialist philosophy joined hands with the mass movement of industrialization, and this movement provided the false assumption that man has an unlimited ability to dominate matter and to be a complete master of himself. This process produced mass libertarian ethics in both the West and the East, in both capitalism and socialism. In this way, and in this mass culture, the principle of pleasure came to prevail over the principle of reality, and traditional sexual and family morality found itself supported by a Christianity which was much weakened. Thus it was, *inter alia,* that sexual libertarianism gained widespread currency in the form of divorce advocacy, the anti-family mentality, homosexuality (also justified in theoretical terms), pornography, and the abortion mentality.

But within this general framework the abortion phenomenon has its own special connotation which springs from the particular social phenomenon of which it is the expression. The abortion attitude is a synthesis of hedonism and desperation.

The hundreds of millions of possessive hedonistic individualists generated by the emancipated bourgeois culture transferred to the masses by

Socialism and by the trade union movement do not now find themselves face to face with the overcoming of poverty. On the contrary, they have before them evident limits to development, ecological disaster, population presure, and new forms of crime—in short, the partial failure of materialism, a failure which is both material and spiritual. It seems that one cannot but be bourgeois. But today there is a risk that one can no longer manage to be so. This means that we have before us both the ideological triumph of industrial culture and its human and *de facto* crisis.

Libertarian abortion is, therefore, a phenomenon of moral dissoluteness and of despair. Its dissoluteness is promoted by this triumph; its despair is encouraged by the crisis of materialism. During an age of crisis, once it is assumed that transcendent ethical norms have no basis, it is no longer worthwhile to defend lives which compromise the well-being of those already in this world; lives which are seen—if they are even allowed to begin—to be destined for a world perceived in dark and pessimistic colors.

In addition to the selfish calculation of "Let's remain few in number and thus go on living well in this world," great emphasis should be placed on the existential pessimism which is present in our crisis-locked societies, something which leads the fact of being born today to be considered as a negative fact.

"I enter an integrated planning of the economy and of society/nature," observes Lombardi Vallauri, "and the libertarian element is losing, is provisional; one can only go towards integrated socialization. I enter the physicalistic world of `nothing-other-than' (from the nothing other than the world of quantity and quality), and man is lacking in ontological essence. He is a process which can be calculated and molded, his human essence becomes distributed in sovereign and historical terms by society. And it is society which confers the right to exist on people."

In the libertarian project this ontological right of the unborn child is confiscated by the mother. Will it not pass on in the future to the trade union, the party, or the planning office? I enter materialistic immanence and totalitarian abortion has at least the same chances as libertarian abortion. Indeed, collectivism will probably prevail at the final reckoning over individualism."

It should be observed here that in many environments there has been falling off in educating people to approach reality with their rational faculties. This is because attachment to sense impressions prevails (or at the most a more sophisticated version of it, namely ethical sentimentalism) and according to this creed only the person who manages to provoke feelings is of importance—that is, feelings of sympathy or pity: the child who already laughs or cries, but not the baby who has not yet made his appearance. (The adult, it may be observed, is respected because he has strength in his arms or in his mind.)

At base, materialism is still metaphysically present but with a psychological application which should be investigated separately: one needs to identify in practical terms, within the realm of psycho-sociological root systems, what the reasons are for the fall of reason. For without reason, without the concept beyond the senses, it is difficult to understand the truth that even a life which is not fully life is in essential terms life and that there exists a duty to respect life in a universal sense.

Libertarianism, it should be added, has its matrix not only in the civilization of (assumed) abundance but also in the belief that without the "Hellenic" metaphysical construction of the world (there is an order to being wanted by God) order is given to the world by man by his own decree.

Today there are indeed some theologians, both Protestant and Catholic, who say that God wants a world in which man himself gives meaning to things and to life. In this case there is a need, without in any way ignoring the difficulties of finding an audience in today's world, to refine the ancient metaphysical truths, as well as those of an ethical character. It is certainly true that in today's world there are forms of non-nihilistic secular humanism which are open in a positive sense to interpersonal values and to respect for the life of others.

In the past there was a bourgeois ethic of sobriety and discipline. Today, there are humanists, Socialists and non-Socialists, yesterday and today there were and there are philosophers like Rousseau, Kant (who, to tell the truth, were not atheists), Croce, and yet others who did not agree with destructive and nihilistic libertarianism. In their works there is often to be found the implicit influence and presence of the Christian inheritance.

Secular humanists often do not defend their values by choice but by feeling (we are dealing here with an emotion, a passion which does not have theoretical bases). One can see here that one needs not so much to see that this emotion is invalid but that the basis of its validity lies in its deism. Where it is not said that everybody feels the emotions that we ourselves feel, a revealed (or philosophical-theoretical, deistic) justification is a universal right. One could add that a perspective which gives hope of immortality can confer effective and practical force to injunctions not to search for the unlimited satisfaction of the needs of the men of today. In this case, true enough, the secular humanitarian would not be personally put into crisis. Only his trust in the possibility of the widespread diffusion of his ideas would be put into a state of crisis, a possibility based upon the simple structure of his principles

which are, from the point of view of an effective base, clearly inadequate.

But this is not enough. It is not enough to invite people to opt for Christianity because this is the most solid point of departure for a universal diffusion of humanitarian ideals.

Only if objective arguments can be presented can one go forward to a Christian proposal of universal cogency. And in such a context the problem becomes one of studying the arguments in favor of deism (and of Christianity) which can strike a chord with secular humanists. And this means that we must investigate the specific reasons for their refusal of deism (and of Christianity). These reasons will not be the same as those which led to hedonistic libertarianism (not, therefore, those of industrialism, etc.) but there must be reasons, and various reasons, given that the theoretical approaches of the secular humanists themselves take various forms.

Similar (but not, obviously enough, identical) things may be said in relation to the roots of the defense of euthanasia. At base here as well there is a radical hedonism according to which life should only be lived in happiness and unhappiness should be excluded.

As Caludio Magris writes, "It seems that there is an ever greater diffusion of the mentality which holds that to have the right to life one should be in possession of happiness. The religion of happiness is becoming ever more accepted, a process which implies the falsehood that we can need to live with pain from our individual and social lives." Either happiness, or nothing.

In support of an attitude which is favorable to euthanasia there is also another factor which is very widespread in contemporary culture. "The emphasis on the need to achieve subjective self-fulfillment leads to an exaggerated search for ways of being and of living which tend to exclude any perspective which involves limiting desire." (G. Piana)

To live as old people and to live as seriously ill people certainly means—it should be pointed out—to live in the acceptance of not embracing certain values. Let us suppose that we should accept a spontaneous vision of life which does not accept the disciplining of immediate impulse, a vision which does not tolerate sacrifices for the sake of future superior goods. If such were the case it would be logical to conclude—it may be observed—that if the need and the positive character of the sacrifice cannot be seen where it is most clearly seen as being necessary precisely because it will lead to a future good, the acceptability of the sacrifice itself will not be perceived *a fortiori* where the positive aspect is less evident (even though it is real)—an aspect which must and can be looked for in the privations of old age or painful illness.

The cultural orientations which we have referred to act powerfully to produce an ethical climate in today's world which is incapable of recognizing the positive nature of life in every situation and in every state.

There is also a third factor at work: the modern world—quite apart from the contrasts between capitalism and socialism—lives in the dimension of the transformations of the world, and thus in the dimension of the future. It is quite natural, therefore, that youth is prized, that there are spasmodic attempts to always be young, that the idea of old age is rejected, that efficiency, the capacity to work and to produce, in a word utility, are seen as the most important values that there are.

We need to ensure the widespread rediscovery of the value of generosity, of giving. This is also a decisive value—if a brief digression is allowed—in the achievement of a different attitude towards the generation of human beings, towards birth, and thus towards abortion.

This value of generosity in giving life can also be recognized at the level of psychological reflexes which can be experienced directly.

A recent book by the great psychologist Erik Erikson makes the following observation: "When generative enrichment in its various forms fails completely, it is easy to come across regressive moves towards previous states both in the form of an obsessive need for false intimacy and in that of an excessive and exclusive concern with one's own image. In both cases there is a widespread sense of stagnation. This should be understood with reference to the specific importance of its state. This is especially important today, at a moment when *sexual frustration* is seen as an iatrogenic cause but when *generative frustration* is not seen in the same way, and this because it is subject to the dominant technological *ethos* of birth control."

But here the argument becomes too wide-ranging, and I must here conclude what has already been a long paper.

Professor ADRIANO BAUSOLA
Chancellor of the Catholic University of the Sacred Heart, Milan, Italy

TADEUS STYCZEN

The Origins of the Concept of the Person: Four Variations on the Suggested Theme

Introduction

I will begin with a confession. When I received the invitation to discuss the subject of "the origins of the concept of the person" my thoughts were drawn to the First Man of the Book of Genesis and to the moment of his impact on the fact of the world.[1] Adam looks at the world of objects, wants to identify them, and thus defines them and gives them suitable names. But he soon realizes that there is not one which is surprised at the world, as he is. With increasing amazement he observes that he is different from the rest of the world. And even if the world is his home, he feels uncomfortable in this home -foreign and strangely alone. The amazement created by looking at himself in the light of this difference generates within him a need to ask himself a question about himself: in practical terms, who am I?

I suppose that for the organizers of this international conference on the theme: "*Vade et Tu Fac Similiter—From Hippocrates to the Good Samaritan,"* who have asked me to discuss the subject of "the origins of the concept of the person," it is precisely this question to which I should devote myself. In the paper that follows I would like therefore to propose to those who are listening to me that we accompany the First Man on his path towards self-genesis and that together with Adam we thereby discover a self-portrait of our own personal and spiritual physionomy.

The question of the "self-genesis" of man which is dealt with in the first pages of the Book of Genesis by the inspired author of the Old Covenant has, one might say, a "secular" equivalent in ancient Greece. This equivalent is to be found in the introduction by Socrates to the problem of the "anthropological turning point" at the very center of philosophy. The sage of Athens believes that the mission of the philosopher is to make his disciples aware of the need to "generate themselves" through self-knowledge ("Know yourself!") and he himself of course became a martyr to this cause through the adoption of such a course of action.

However, this question finds its zenith and its full enlightenment only in the New Covenant. It already appears at the very beginning of the mission of Jesus Christ when he engages in a conversation with Nicodemus. During this conversation the Master of Nazareth wins over a "pharisee" who is fully convinced of the need "to be born again" (cf. Jn 3). And thus it is that the question of the birth of man as a liberation of man from man through knowledge of truth and a decision in favor of that truth *"know the truth and the truth will make you free"* (Jn 8:32)—is placed at the very center of the message of the gospels. Around it revolves the entire oral message in an almost monothematic composition, a message crowned by the death on the cross of Him who communicates it.

Jesus Christ is the *new Adam* who expresses within himself the ideal man, who creates him "in the suffering of the passion" and in the fullness of the freedom of the truth until the victorious "everything has been achieved" of Golgotha. In this context the *"Ecce homo!"* of Pilate (Jn 19: 5) is a deeply important comment on the question of Jesus of Nazareth, a comment which has proved highly instructive to this day. Indeed, that comment came from the mouth of a man who a little time previously "had liquidated" the solemn declaration of the Accused with the ironical observation of a skeptic: "What is truth?." The Accused had declared: "What I was born for, and what I came into the world for, is to bear witness to the truth" (Jn 18:37-38).

The "Ecce homo!" of Pilate links the question of the ideal of man with the question posed by Socrates. It illuminates itself with the light of the Gospel. Nothing which is authentically human is alien to God who, for the sake of man, appears on his path. Thus was it that St. Thomas Aquinas observed: *"Gratia non tollit naturam sed eam supponit et perficit."* Thus also do we understand the reason why "the question posed by Socrates" has always been present in the history of the philosophical and theological thought and debate of Christians in relation to the question of the spiritual birth of man.

We do not know the name of the Christian who in enthusiastic fashion wrote the text of the Hippocratic oath in the form of a cross on a parchment. But we do know the name of another Christian who after centuries had passed did almost the same thing with Socrates by bestowing the title *Scito Te Ipsum* on his own work of moral theology and suggesting that the litanies of all the saints should end with the invocation: "St. Socrates! Pray for us!" And this because of a perceived "baptism of blood." That Christian was Abelard! This is a parallel which is very striking. E. Gilson even speaks about the "Christian Socratism" of the Fathers of the Church of the East and the West, and goes on to draw attention to the exceptional contribution of B. Pascal to the crystallizing of the personalist approach to the discipline of philosophy.[2]

1. The Subject and the World

I have already mentioned that "the origins of the concept of the person" are to be found in the contact between

man and the world. It comes through an act—and at the same time a fact—of knowledge. In this contact man becomes struck by the contrast between the world and himself. Man feels a shock at the discovery of his own diversity in relation to the world and lives out his loneliness at the very center of that world. He feels his separateness within it. And it is precisely this contact of knowledge with the world which initiates, together with the history of self-knowledge, the history of the birth of the concept of the person. And this—the act of knowledge—frees within man the beginning of the history of the whole of his great adventure with the world and with himself on the stage of his own interior—something which for him becomes at the same time the central stage of his world. Man sees that he is the only actor on this stage and at the same time the only spectator of his own performance: the *dramatis persona.*

In searching in the world for someone who can share his amazement at the world, Adam finds that person only in himself. And he then concentrates his amazement upon himself when he discovers that what makes him different from the world is what at the same time distinguishes him from the world.[3] The depth of the spell which accompanies this self-discovery is paralleled by the death of the fear which grows within Adam at the discovery of his own *loneliness* amidst the world. "The eternal silence of infinite space frightens me...through space the universe surrounds me and swallows me up like a dot; through thought I understand it...I must not seek my dignity from space but from the correct use of my thought."[4]

Thus does Pascal see the interior of Adam in himself—the person and his dignity. With a spiritual gaze Adam directly touches his own *"self"* as a subject in contrast with the *"this"* of the objects of the world.[5] He discovers within himself the person as a subject of knowledge.

Is man, however, a person only because of the fact that he is the subject of knowledge? If such were the case the dramatic confession made for us all by Ovid—*"Video meliora proboque deteriora sequor."*[6]—would not be possible in the biography of any man. St. Paul would make the same confession with the words: "what I do is something I have not the will to do." (Cf Rm 7:19). In characterizing the person, therefore, as a subject of knowledge do we not perhaps present a "partial definition"? That is to say a definition which, by perceiving the first person in the question of the essence of the person, actually pronounces the last word on such a question.

2. A Subject of Knowledge and A Subject of Freedom

By now we can understand that we are next to Adam (and ourselves) like a subject in front of a subject of freedom—that is to say in front of someone who is himself thanks to the

fact that in knowing truth he does not cease to continue to depend upon himself. Does not man, however, in knowing truth commit himself to knowing it also through acts of choice in order to remain loyal to the end to truth and to himself—that is to say to his own identity?[7] Indeed, thanks to the personal perception of this truth he can but observe that he guides and governs himself only when he allows himself to be guided and governed by truth. With the power of his own liberty would he condemn himself to the tragedy of loneliness, that loneliness which gave rise to the cry of St. Paul: "Pitiable creature that I am!"?[8]

John Paul II has observed: "In truth is contained the spring of the transcendence of man in relation to the cosmos in which he lives. It is precisely through reflection on his own knowledge that man reveals to himself that he is the only being in the world who sees `from within', that he is bound to known truth, bound and thus also `obliged' to recognize truth, if needs be, also through free choice, through acts of witness in favor of the truth. This is the capacity to rise above oneself in truth.... Man merely observes that he is a personal subject, that is to say a person. He is placed face to face with his own dignity."[9]

It is precisely here that man reveals to himself the question of his own moral identity through the recognition that he is an actor burdened by the exclusive responsibility of finding the solution to this problem, a question which is a supreme personal drama, a question relating to whether he should or should not be himself.

What does this actually mean in more precise terms?

First of all I would like to say that the man-person is somebody who continues to be unable to see himself as long as he does not see within himself someone to whom, through a free act of choice, it is not absolutely legitimate to deny the truth of he himself recognized through a cognitive act. Secondly, this means that man can nonetheless deny that which he should absolutely not deny: man is an actor who can use the power of his own freedom to deny the truth which he himself recognizes. Thirdly, this means, indeed, that the man-person—who in fact decides to deny a truth which he himself perceives—inevitably works for the decomposition of the compactness of his personal structure as a union of the subject of knowledge and freedom: that is to say the union of a rationally free "self."

Indeed we need only consider the following: what happens then to the actor, and more precisely what does the actor do to himself, when through an act of freedom he denies the truth which he himself as a person recognizes through his own cognitive act? The truth remains the same. But does the subject who as a subject denies the truth and at the same time recognizes it, as the subject of knowledge, as truth, go on being that which he was—that is to say himself? Indeed by lowering himself as a subject of freedom to something which he himself does not approve as a subject of knowledge, he freely falsifies his own "self" through introducing by the same act (within the sphere of his ontic "self") that "self" which he has denied—that is, a "nonself." And he always does this when he yields, whether freely or unfreely, to

something which he himself does nor approve—that is, to something which overwhelms him. He thus gives in personal fashion his own self-dependence, his own independence, which is in the grip of some external power, to heteronomy. And he thus renders himself and his own independence slaves through the power of his own freedom. Can we imagine a greater slavery than the self-slavery which is caused by this self-hypocrisy?[10] Can we think of a deeper fracture within oneself which is deeper than this?[11]

Thus we find the method of *per opposita cognoscitur* which enables us to achieve a clearer completion of the definition of the lines of our self-portrait as persons. The person is the self-dependence of a subject ("self" from "self") which comes about in one's own act of making oneself dependent upon the only power which does not make a slave of the subject—the normative force of truth known by the subject.[12] I am myself always and only when of my own accord I render myself dependent on myself, but I make myself dependent on myself always and only when through acts of free choice I render myself dependent on the truth which I affirm and recognize as being independent of myself. The truth goes beyond myself.[13] For this reason I remain myself and I assert myself in my own compactness and integrity always and only when I go beyond myself towards known truth—affirming it until the end through acts of free choice. In my personal essence as a union of subject of knowledge and freedom, I unify myself always and only as a witness of truth in its highest expression when I am its guardian and steward. In truth, the man-person is a priest at the service of truth at two inseparable levels of such service: at the level of the steward of the truth and at the level of the steward of the steward of truth—in himself...

For this reason woe to the person, not to truth, if the person betrays truth. Thus it was that St. Paul did not say: woe to the Gospel if it is not preached but, rather: woe to me if I do not preach the Gospel. *Vae mihi!* Karol Wojtyla, on the other hand, expresses the essence of the personal structure of man with the words of a poem which bears the significant and meaningful title: "birth of the confessors": "But if truth is within me then I must explode. I cannot reject it, if I did I would reject myself."

And what would happen if I were to refuse it? Then I would condemn myself to a tragic loneliness in relation to myself, loneliness being the close relative of despair. Indeed, the person as a rationally free subject cannot but on the one hand condemn himself for the schism caused by himself within his own structure, and on the other observe that he does not possess within himself the least power by which to annul the effects of the rupture caused within his inner being. He does not have the power to make an act which he has performed nonexistent, and make that which is its inevitable consequence null and void. From now on he must always remain a witness and a judge of

himself as the creator of the tragic victim of his own suicide. The person, indeed, must look for ever upon the work of his own self-destruction and condemn himself for having carried it out. He is the creator, the victim and the judge—all in one person—of his own tragedy.

In *The Divine Comedy* Dante expresses the tragic quality of this situation with the words: "Abandon hope all ye who enter here." And he places these words above the gates of hell. Sartre defines the same internal state of the person with the title of a play—*Huis Clos* ("Behind Closed Doors")—a sentence which the English render well with two words: "No Exit." Françoise Sagan on the other hand, the author who comes from the land of the cock-crow, greets this despair with the following declaration: Hello sadness!

Per opposita cognoscitur.

The question of choosing whether to be or not to be ourselves is a "yes" or a "no" to truth. It is not right for me to deny the truth of which I am cognizant! I govern myself when I allow myself to be governed by the truth. I make myself dependent upon myself when I make myself dependent upon the truth. When I despise the truth I despise myself. I remain myself, and affirm myself within myself, only when I rise above myself through an act of free choice in the direction of the truth of which I am aware. Only truth, therefore, makes us free...

I understand the conclusion to the reflection undertaken hitherto in the following terms: I see myself within myself as a person and I define my conceptual features when I observe how I am someone for whom it is absolutely wrong to deny the truth which I have recognized. Or to put it another way: when I myself place the sign of equality between myself and the placer of truth.[14]

Obviously enough, nobody can take the place of somebody else in performing the act of personally seeing this truth, an act which constitutes the beginning of self-genesis as a person. Each person must personally know the truth which makes him free, and each person must personally choose it so that it frees him in real and effective terms. Another person, however, can help him (as Socrates perfectly observed) to see the truth and that person can thereby become the midwife of his birth, and thus, necessarily, the midwife of the genesis of his vision of himself as a person.

Thus it is that even the author of the words: "Know the truth and the truth will set you free" (Jn 8:32) halts full of respect before the threshold of the freedom of man, the threshold of the freedom of the person. Christ leaves Nicodemus with the task of giving himself rebirth but he does everything to engender within him the work of self-genesis. From this point of view Christ, the New Adam, goes infinitely beyond what the author of the famous Psalm 8 had been able to understand.[15] God the creator throws the whole world at the feet of Adam and now throws himself at his feet as God-Man, the *Redemptor Hominis,* in order to fascinate and touch man with truth about his greatness and thus help him to choose his own greatness and uphold it until the

end. *Deus homo ut homo Deus!* Gregory Nazianzen would proclaim when astounded by the offer of the crucified God-Man.[16] But St. Augustine would rightly add to this: "Who created you without you, will not save you without you."[17] Man must be born of his own accord. However God is constantly waiting for man to allow him to help him in this birth. He waits and constantly enjoins him—and this because of the fact of the Incarnation—to ask himself that great question of Anselm of Aosta: *Cur Deus Homo?*[18]

For this reason once man asks this question he will have made a good beginning. Indeed, man thereby places himself in the visual field of God-Man.[19] "The trials and tribulations of birth" (Rv 12:2) of man in himself—together with every possible temptation to surrender and to fall into the abyss of despair—from now on will always be shared by man with the "trials and tribulations" of the God-Man, the Good Samaritan who kneels before him.[20]

Let us allow Pascal to speak once again: "Knowledge of God without knowledge of one's own lowness generates pride. Knowledge of God without knowledge of one's own lowness generates despair. The knowledge of Jesus Christ is to be found between two extremes because in that knowledge we find both God and our own lowness."[21]

Summary and Conclusion

There is a birth which occurs and there is an end to it. And there is a birth which must be the work of our own hands. In both cases man is the subject but in both cases he is a subject in substantially different ways. In the first case man is the subject and becomes himself with he "to whom something happens" (personal *suppositum*)—that is, he who becomes and is himself because of his own nature. In the second case, on the other hand, man himself becomes and is the subject, himself, because of his own act of knowledge of truth and the free choice in favor of truth (personal *subiectum*). This birth is the personal work of each man on his own. The man as the subject of this kind of act at the same time demonstrates himself to himself and to others: by imprinting himself in a certain sense in such acts as their creator he at the same time through such acts expresses himself to himself and to others, he expresses himself in them as a person through his own action. "Through the act the person becomes "someone" and also manifests himself as "someone" (K. Wojtyla). The birth of the person is in this sense also the birth of the concept of person.

Nobody can take the place of another person in this birth. Each person must be born alone. Even God, for "God cannot save man without man" (St. Augustine). But because man nonetheless can actually be born he has an indispensable need for God. God wants to concede this new birth to him and to do this God made himself man, and he did this in order to be constantly available to man like the Good Samaritan. Man, however, continues

to remain free. He is not obliged to accept the offer of God-Man. Indeed, he can reject it.

Professor TADEUSZ STYCZEN
Member of the Pontifical Academy for Life,
Professor of Ethics at the University of Lublin, Poland

Notes

1. Cf Gn 2:18. Cf. John Paul II, *Uomo e Donna lo Creò. Catechesi sull'Amore Umano*, (Libreria Editrice Vaticana, 1986), chapter one, "Il Principio," chapter five "Il Significato dell'Originaria Solitudine dell'Uomo," pp. 44ss.

2. Cf ETIENNE GILSON, *L'Esprit de la Philosophie Medievale*, (Paris, 1943), chapter IX, "Knowledge of Oneself and Christian 'Socratism'." This point is also underlined by the eminent contemporary historian of the history of philosophy, and equally eminent philosopher, Augusto del Noce, who died only recently. Cf R. BUTTIGLIONE, *Augusto del Noce.Biografia di un Pensiero*, (Piemme, Casale Monferrato, 1991). In the same spirit is to be understood the contemporary Italian philosopher of law, SERGIO COTTA. See his "Etica e Diritto. Dall'Unità al Completamento," in *Studi in Onore di Manlio Mazziotti di Celso, (*Cedem, 1995), pp. 287-294. Cf also JOSEF SEIFERT: *Essere e Persona. Verso una Fondazione Fenomenologica di una Metafisica Classica e Personalistica*, (translated with an introduction by R. Buttiglione, Milan, 1989).

3. In a section with the meaningful title (in the Polish version) of *"Man in search of his own entity"* JOHN PAUL II characterized the condition of the "first man" in the following way: "Thus the created man, from the very first moment of his existence, finds himself face to face with God and is almost in search of his own entity—one could say in search of a definition of himself. A man of our times would say *"in search of his own 'identity'."* The awareness that man is "alone" in the visible world and in particular amidst living beings has a negative meaning in this search because it expresses that which he *"is not."* Nonetheless the awareness that he cannot in essential terms identify with the visible world of other living beings (animalia) has at the same time a positive aspect in relation to this primary search—even if such an awareness is not yet a complete definition it nonetheless constitutes one of its elements. If we accepted the Aristotelian tradition in relation to tradition and anthropology, we would have to define this element as a "near kind" (*genus proximum*). *Uomo e Donna, op. cit.*

Because of the importance of the text of this passage it should be quoted in full. But because that is not possible here the reader who is interested in a closer analysis of this line of thought should make his own way to the passage.

4. B. Pascal, *Pensieri e Altri Scritti su Pascal*, (Edizioni Paoline, 1987), an integral version from the French taken from the Brunschvicg edition (1897/1904), nos. 206, 347, 348. The text cited shows that "the thought" of Pascal is synonymous with knowledge or science and is opposed to the Cartesian way of understanding the phrase "I think" ("cogito"). For this reason the "anthropological turning point" of Pascal is also radically different from the Cartesian "anthropological turning point" and from the position of the German idealists, thinkers who belong to the same school of thought.

5. In relation to these he is "different" from and "higher" than everybody.

6. OVID, *Metamorphosis*.

7. Cf. A. SZOSTEK MIC, *"Wolnosc—Prawda—Sumenie"* (Freedom -Truth—Conscience), in *Ethos*, n. 15/16 (1991), p. 27.

8. Cf Rm 7, 24.

9. Cf. JOHN PAUL II, *"Responsibility for the Known and Communicated Truth,"* address given to the world of Polish science and learning at the great hall of the Catholic University of Lublin, 9 June 1987, published in *La Traccia*, no. 6, year VIII, July 1987, p. 724.

10. It it worthwhile here to observe the context in which the words of Christ ("You will come to know the truth, and the truth will set you free") are spoken in the Gospel according to St. John. The words which follow shortly afterwards—"Every man who acts sinfully is the slave of sin"—go to make up the answer of Jesus to the declaration of those taking part in the dialogue who strongly deny that they have ever been in a condition of slavery. "We are of Abraham's breed, nobody ever enslaved us yet; what do you mean by saying, 'You shall become free'?" (cf. Jn 8:30-34).

11. It is clear that the caricature of freedom is

also a form of freedom. But what distinguishes freedom and by its own act rises above (transcends) itself "towards truth" and allows itself to be orientated and guided by truth is precisely the fact that such freedom remains in harmony with its original impulse, that it accompanies the cognitive act of the subject from that very moment at which the subject, through this act, effects an assertion of truth. If John Paul II called his encyclical *Veritatis Splendor* an ode in honour of freedom, this means that he wanted first and foremost to distinguish the freedom which is in truth from a freedom which reflects its own dynamism onto itself. He also wanted to give a warning about the tragic possibility that this deviation could become a mere self-deviation. I think that it is precisely at this point that we must engage again in a clarifying dialogue about the essence of freedom with thinkers such as L. Kolakowski, thinkers who state that true freedom (bound to truth) is not freedom. See, for example, Kolakowski's critical reflections and observations on the *Catechism of the Catholic Church*.

[12.] Cf. T. STYCZEN SDS, *Wolnosc w Prawdzie*, (*Freedom in Truth*), (Rome, 1988). See by the same author: "Solidarni: Wolni Przez Prawde" (With Solidarity: Free Through Truth), in *Ethos*, 3 (1990), n. 3/4, (11/12), pp. 5-9.

13. Cf. KAROL CARDINAL WOJTYLA, "The Self-Theology of Man and the Transcendence of the Person in the Act," contribution sent to the VI International Congress of Philosophy organized by the Faculty of Letters of the University of Sienna and the Faculty of Magistero of the University of Arezzo, Arezzo 1-5 June 1976. For a version in Polish, see KAROL WOJTYLA, "Osoba i Czyn Oraz inne Studia Antropologiczne," the Catholic University of Lublin WTN, 1994, pp. 478-490, especially p. 489.

[14.] Only then do I see myself as a person, that is to say as someone whom I must generate within myself unendingly. Unendingly. This parent is not ipso facto, it becomes so when the acts are taken to rise above oneself (open oneself) as a subject of freedom towards the truth which is already affirmed in the act of knowledge of truth. This amounts to "not hardening the heart" to the voice of truth which is already known and by that very process recognized as such.

1[5.] See *Psalm* 8.

[16.] See ST. GREGORY NAZIANZEN, *Sermon 7, delivered after the death of his brother Caesar*, 23-24.

[17.] St. AUGUSTINE, *Confessions*.

[18.] Pascal answers in abstract form:

1) in order to show man the great scale of his fall, if such a major act is necessary to save him;

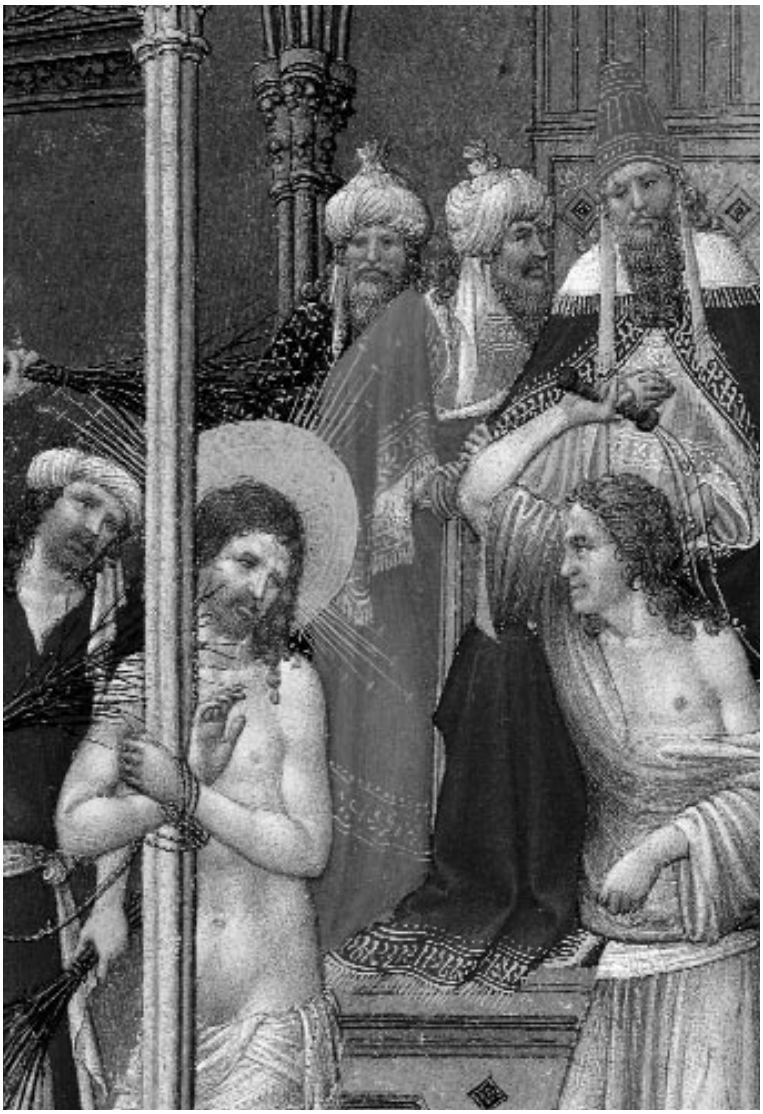
2) in order to show man how great his dignity is in the eyes of God notwithstanding the fall, if God believes that man continues to deserve his intervening action;

3) in order to show man how great God's love for man is if God is prepared to intervene in such a way.

19. "You would not have looked for me if you had not already found me," cf. Pascal, *Thoughts.*

[20.] "God so loved the world that he gave up his only begotten son, so that those who believe in him may not perish, but have eternal life. When God sent his son into the world, it was not to reject the world, but so that the world might find salvation through him." (Jn 3:16-17). It is significant that Christ had already uttered these words during his conversation during the night with Nicodemus. Cf. similar passages in Jn 5:22; 12:47; Lk 19:10; and Acts 17:31.

[21.] Pascal, *Thoughts, ibid*. no. 527.



EMMANUEL SAPIN

The Horizons of Fetal Medicine and its Ethical Consequences

The ethical consequences of the development of prenatal diagnostics and the new prospects for fetal medicine have been analyzed in depth and in an especially perceptive way in the Encyclical *Evangelium Vitae*. Rather than laying emphasis on the dangers which presently threaten and will in the future threaten man, I would like in this paper to dwell upon the present state of, and future prospects for, fetal medicine. My paper will be of a rather technical character, and this is something for which I apologize at the outset. But this approach will, I hope, enable you to gain a realistic idea of the present practical application of fetal medicine and the future prospects of this form of medicine. On the basis of this information which I will offer to you, it will be easier to understand and evaluate the dangers which the encyclical on life has drawn attention to, and it will also be easier to make sure that fetal medicine is directed towards its real aim and purpose, namely the defense of life at the service of man.

Prenatal medicine was for a long time a matter of identifying anomalies which might produce a miscarriage. But in recent years this form of medicine has made great strides because of advances in prenatal diagnosis—something which is now more precise and achievable in diagnostic terms and which also allows a far better assessment of the prognoses of certain illnesses. Prenatal diagnosis now enables us to identify the correct fetal therapy which should be employed but at the same time it also involves the danger that individuals are selected from a medical point of view before they are born. Like conventional medicine, fetal medicine must be seen as being a treatment for a patient, in this case a patient who has not yet been born; at the level of prevention it must be used to identify which women (and which couples) run an especial risk of having a child afflicted by a hereditary illness or by a deformation. Obviously enough, fetal medicine exists to avoid such a risk and in a general sense it provides, as it were, genetic advice.

Whatever may be thought about the way in which prenatal diagnosis is carried out, at the present time such a diagnosis has become a reality. We must therefore give a meaning to prenatal diagnosis which is not merely that of identifying anomalies which could lead to the interruption of the pregnancy. Here, then, is what the *horizon of fetal medicine* should be: the fetus is a human being and if he is ill he must be treated; if there is a risk that he might fall ill then such an eventuality must be avoided; and if nothing can be done then a welcome must be given to him and the parents must be accompanied during this difficult trial and be helped as much as possible.

At the present time the horizon which is actually at work does not correspond in the least to this ideal horizon. Indeed, very *great dangers* threaten to deviate fetal medicine from its true goals, and these dangers are:

—abortion, which is called the medical interruption of a pregnancy, when an anomaly has been identified;
—genetic counseling involving the selection of individuals; and
—the use of tissues from embryos or fetuses.

Behind all these realities is concealed that most difficult problem of the definition of man, of respect for human life whose value, according to the dominant ethics of today's world, is dependent upon and conditioned by the quality of life.

1. Prenatal Diagnosis and Fetal Medicine

At the present time we have all the instruments we need to effect treatment and therapy. This is because fetal medicine has been made more precise and effective by being able to engage in more effective examinations of the fetus through the use of biology, echography, the Doppler, amniocentesis, and the taking of fetal blood from the umbilical cord—to name just some of the modern techniques available. After the diagnosis, decisions have to be taken about the forms of treatment which should be employed, and in this process reference is made to the knowledge that we have about the spontaneous development of certain anomalies, the technical, medical or surgical instruments and methods we have to hand, and the risks these forms of treatment could have for the well-being of the fetus and the pregnant woman.

Employing a simple analytical approach, we can detect two principal situations: the discovery of an anomaly which is already present and the identification of a risk.

The *discovery of an anomaly* leads to the carrying out of tests to discover the cause of that anomaly and to assess the seriousness of the condition. There is than an attempt to analyze the viability of treatment and to evaluate its feasibility, its possible beneficial effects, and the risks that are involved. When such tests have been carried out, and their results have been reflected upon, a form of treatment can be decided upon whose aim will be the removal of the cause of the difficulty or the reduction or elimination of its consequences, and all this to achieve the survival of the fetus. When such a form of treatment can no longer be

applied, or when the anomaly of the fetus places its survival at greater risk or at immediate risk, the role of fetal medicine should involve a gradual preparation of the parents for the trial which awaits them and the creation of conditions by which the newly-born person can be welcomed into this world. In a certain sense we are talking here about a *palliative form of treatment.*

When we are faced with the *identification of a high possibility of foreseeable anomaly,* as for example happens when there is an incompatibility between the blood of the mother and the blood of the fetus or when there is a couple who have already had a child afflicted by inherited illness but who want to have another child, fetal medicine must weigh up the risks which are present and try to avoid them. This is what we term *"preventive treatment."* This should be the task and goal of genetic advice in the broad sense of that term.

The present-day purpose of *genetic advice* is to enable a couple with special precedents to make a decision about whether to have a child in the full knowledge of the real risk that they run and with the opportunity to take advantage, if they so wish, of prenatal diagnosis. An example of this might be when parents have already had a child who suffers from cystic fibrosis of the pancreas or from myopathy. If the couple decides to have another child, prenatal diagnosis (when this is possible) enables the probability of another anomaly to be replaced by certainty about whether the child will or will not be struck by an anomaly. If the child does fall foul of an anomaly, the possible decision to effect an abortion comes into play. The information available to the couple, therefore, enables that couple to resort to abortion when that diagnosis confirms that the fetus is affected by an anomaly. We can thus see that in the logic of genetic advice, coupled with the actual ability to destroy those unborn humans who are struck by an anomaly, there is an evident eugenic philosophy.

2. Therapeutic Methods in Fetal Medicine

There are a whole variety of ways of treating the fetus, and they are as follows:

– the *treatment of the mother* begun before, and continued during, the pregnancy, if the mother herself has an illness which could have serious consequences for the child she carries within her (for example, hypertension or diabetes);

— the *treatment of the fetus through the giving of drugs and medicines to the mother* (as can take place with certain conditions such as toxoplasmosis, listeriosis, syphilis, disturbance of the fetal heart-beat, hypothyroidism, or certain sexual ambiguities);

— *the direct treatment of the fetus:*

a) both through the injection of elements into:

– the amniotic liquid,

– the fetal blood through the umbilical cord,

– or direct injection into the fetus itself;

b) and through means of fetal drainage;

c) fetal catheterism involving the dilation of a blockage;

d) or action effected through the use of fetoscopic methods;

e) or, to conclude, extra-uterine fetal surgery.

As for the question of *gene therapy,* we can observe that its employment in the field of fetal medicine still belongs to the realm of research and experiment. Its guiding principle is the idea of remedying the gene anomaly which is directly responsible for the anomalous condition or the actual substitution of the defective gene. The first practice is still not technically possible. The second is achieved through the transfer of a gene through the viral vectors and the replacement of the viral gene with the gene which is to be introduced. This grafting is carried out ex vivo in live cell cultures where such cells have been removed from the fetus affected by the anomaly. The grafted cells are then reintroduced into the original host organism. When germinal cells are grafted in this way one should always be fully aware of the danger that the human genome might be manipulated or interfered with. To conclude this section, reference should also be made to the *grafting of fetal tissue*. This involves the use of fetal tissue to treat an individual in a fetus state afflicted by an anomaly. When this treatment is applied to man it is employed with people who are already born. The marked capacity of this tissue to develop and the low risk that the tissue will be rejected have led some practitioners to propose and employ this technique.

A couple has a child whose immunity system is severely compromised and who can only survive if he is kept in a sterile environment. A grafting of fetal tissue is then proposed to this couple in order to ensure that their child acquires the immunity defense mechanisms which it does not have, the absence of which, naturally enough, constantly threatens its life. This treatment will allow them to save the child that they see, know and love, and which causes them to suffer as parents. The fetal tissue which is used is taken from a fetus which has been aborted. Should this answer to their problems be accepted or rejected—what a terrible responsibility for these parents! Must they accept the idea that a fetus can used as an instrument of medicine, that it is only a product and not a complete human being which has been sacrificed? I will leave the judgment to the consciences of those present here today.

3. Fetal Medicine: A Real and Authentic Form of Medicine

Rather than offering a complete survey of fetal medicine, I would like to give various key examples of the component parts of this form of medicine.

3.1 Preventive Fetal Medicine

Some parents have had the misfortune to have had a child which has an *anomaly of the neural sulcus*—spina biphida or anencephalia (the absence of a brain). Certain studies have shown that this can be the outcome of a lack of folic acid in the woman. A preventive therapy can be effected when a new pregnancy is envisaged

through the treatment of the woman with folic acid before conception and during the first three months of pregnancy. One study has demonstrated that the risks that such an anomaly can recur falls from 4.6% when there is no such treatment to 0.7% when such treatment is applied. The identification of this lack and its subsequent treatment also allow the risks of having an under weight child to be reduced by a half.

Maternal diabetes can have very serious consequences indeed for the unborn child. The mortality rate in cases of maternal diabetes was 13% in 1960, 5% in 1970 and 2% in 1990. The congenital deformation rate in cases of uncorrected maternal diabetes is three to four times higher than for the rest of the population. If the treatment of diabetes is begun before the pregnancy the deformation rate falls to 0.8%. If the treatment is begun only after the eighth week of pregnancy the deformation rate is 7.5%. A treatment which ensures a correction of the glycemia to the highest possible extent often leads to an avoidance of these very serious consequences of maternal diabetes. For this reason there must be an identification of the presence of diabetes before the pregnancy begins but also during the pregnancy. The same applies in cases, for example, of maternal arterial hypertension.

In cases where there are fears of a very premature birth a treatment can be applied to the mother which will stimulate the development of the lungs of the fetus and avoid neonatal intracerebral bleeding.

3.2 Curative Fetal Medicine

At times prenatal examination will not only allow a diagnosis of a fetal anomaly but will also reveal that the fetus is reacting very badly to this anomaly. The situation can be so critical that the life of the fetus is endangered even before actual birth. In the same way the normal development of the fetus can be so compromised that very serious complications can take place if nothing is done before the moment of birth. In other cases the life of both the mother and the fetus can be placed in serious danger if nothing is done before the moment of birth.

Certain very serious situations can be detected before birth through the use of an echographic scan and in certain cases these can be remedied through the application of prenatal treatment and therapy. Such is the case with *fetal blood transfusion* effected by means of a puncturing of the maternal wall when there is an incompatibility between the blood of the fetus and the blood of the mother. In the same way, a *fetal drainage system under echographic control* can be placed between a large lung cyst and the amniotic cavity. In very exceptional circumstances *ex-uterine fetal surgery* can be proposed. This form of fetal treatment seeks to ensure the survival of the fetus, to avoid serious consequences caused by the operation so that the organs of the fetus develop well, and to avoid a birth which is premature.

Let us take the case of a woman who is expecting twins, one of which is able to develop normally but one of which is not. The healthy twin develops at the expense of the well-being and health of its brother. This is what is termed the *syndrome of transfused-transfusor* which can lead to the death of one of the twins and to the other twin having his life endangered. Thanks to the techniques of fetoscopy and the use of miniaturized optic fibers we can now use a laser to remedy the intraplacental communications between the twins and thus achieve a harmonious growth of them both.

In certain cases at the end of a pregnancy an anomaly can emerge and develop very rapidly and this can involve great difficulty for the fetus—if action is not taken speedily the life of the fetus can be endangered. A premature birth can be programmed using a Caesarian operation after a therapy has been begun which promotes the cerebral and lung development of the fetus. In this way the newly-born child will be less weak and fragile after his birth.

In other cases the prenatal detection of a fetal deformation enables the birth to be organized in a special center where the newly-born child can be looked after. This will avoid mistakes being made in the form of treatment which is chosen and can prevent treatment being applied too late or in the wrong way. It can also allow a weak newly-born child to be transferred to another location more easily later on.

3.3 Palliative Fetal Medicine

In other situations prenatal diagnosis does not lead to the possibility of applying preventive or curative forms of therapy. When such situations arise there is the problem of informing the parents about the condition of the fetus and we have to deal with the responsibility of the medical doctor who is faced with the anxiety of the parents who know before the birth of the child that an anomaly is present which cannot be treated. In such cases abortion is often suggested as a solution to these desperate parents. When faced with this decision we often encounter a flight from handicap and from illness, and a rejection of what is both predictable and unavoidable grounded in a fear of suffering and death. But at the same time the search for the perfect child—a search which is part and parcel of the law of supply and demand, where, it may be observed, the supply is the outcome of medical advance and the pride of doctors and their science, and the demand is a demand by the parents for effectiveness in producing a child which conforms to their wishes and aspirations—can even lead to legal action when an anomaly is not detected or when doctors are unsuccessful in the actions and treatment they promote.

Some Reflections

In order to render my paper lighter in tone and content, I have not sought to deal with questions raised by the discipline of bioethics. These questions require separate analysis and consideration.

Although the means and instruments of prenatal investigation and analysis become ever more effective and act to show that the life of a child begins well before his birth, it is also true that at the same time these new opportunities, this new field of action for the power of man, lead to old

demons being brought back to life.

The respect due to a human being becomes dependent upon his quality of life: some lives, it is argued, are not worthy of being lived! The evaluation and assessment of the value of life has become dominated by the affective aspect and dimension which takes the place of any kind of deep reflection or consideration about the respect due to a human being. This leads to decisions which are guided by a sort of humanitarian compassion. The human being, it is believed, is, as it were, only a real human being when he is wanted.

How can we accept this euphemism of "embryo reduction" in the case of selective abortion carried out when a medically produced pregnancy involves a multiple pregnancy and when that pregnancy will not produce a live child unless some embryos or fetuses are not destroyed or may actually put the life of the mother in danger? Here we are faced with realities which go beyond the most sinister of deceits.

The lack of an ability to treat a detectable anomaly before the birth of a child inevitably leads to the proposal to abort. In the case of a chromosome anomaly, as for example with the trisomy 21 syndrome, we are dealing with nothing less than the conscious selection of individuals, and this amounts to eugenics. In the case of an inherited illness such as mucoviscidosis or myopathy this is part of the philosophy of euthanasia, and more particularly of prenatal euthanasia. Questions relating to economics, to the financial funding of policies of social protection, can encourage the identification and the destruction of the embryo or fetus which is afflicted by anomaly rather than the removal of the handicap or the reduction of its consequences.

The absolute reference point of modern man is science. What science does not understand does not exist. Where science cannot act and be effective there is a failure and this failure, even if a human being is involved, must be eliminated.

In conclusion, as has been shown through the examination of certain examples, fetal medicine can be seen as a form of medicine in the noblest sense of the term. But the practice and the directions taken by this form of medicine raise very important ethical questions indeed.

We must engage in an enlightened system of custody and stewardship to always bear in mind that a human being exists from the very first days of conception and that each and every anomaly which afflicts that human being is not a mere idea or concept but something which affects a living being who commands our absolute respect.

Love is not learnt through science!
Where is Man in all this?
No! The Embryo and the Fetus
are not the only beings
to be in danger!
We must be his Good Samaritans.

Professor EMMANUEL SAPIN
Specialist in Pediatric,
Visceral, and Urological Surgery
at St. Vincent de Paul Hospital, Paris

BRUNO SILVESTRINI

Respect for Life and Biomedical Research

Introduction

Scientific and technological research is an activity which is written into man's nature; it satisfies one of his inescapable needs. At times, however, it works against him. This is a very old problem but perhaps it is felt more keenly today because our ability to act upon nature has grown out of all previous proportion. This was seen when all the benefits created by the theoretical and practical advances achieved in the sphere of physics were called into question by the explosion of the atomic bomb and by the subsequent emergence of such other very serious dangers as those involved in the peaceful use of nuclear energy. At the present time biology presents the greatest threat because after centuries of torpor it is now rapidly closing the gap which had previously opened up between this discipline and the other sciences. Through the use of modern medicines and drugs—which are exogenous substances capable of changing the functional mechanisms of living organisms—biology has defeated many fatal or incapacitating diseases. It has also greatly reduced the impact of others and has so advanced in the sphere of agricultural production that millions and millions of people have been saved from starvation. Biology has also impinged upon the molecular bases of life and has shown that it can directly act upon genetic errors and can also correct them.

At the same time, however, many dramatic events have occurred such as the thalidomide tragedy, the ecological disasters caused by pesticides, the massacres produced by devastating biological weapons whose development is closely linked to advances in the world of medicines, and the wild and uncontrolled manipulation of DNA. This last opens up prospects which are even more worrying. In such circumstances the eternal questions about the meaning of progress and the principles upon which progress should be based are raised once again and with renewed force. In the past it was the discipline of physics which did this, moving as it did from being an experimental science to being a philosophy. Now biology must do this, and in this endeavour this discipline enters onto what is, for it, an unusual terrain. Respect for life in biomedical research will be discussed in this paper with reference to this reality.

1. The Bioethical Debate

In the above-outlined context, the discipline of bioethics has emerged into the light of day. "Ethics" committees are asked to perform two tasks, which are treated in various ways, with differing levels of responsibility, and involve changeable degrees of investigation. These tasks were described by the Council of Europe in 1989 in the following ways:

a) "inform society and public powers about scientific and technological advances achieved in embryology, in research, and in biological experiments;"

b) "orient and monitor their possibilities of application, evaluate their results, and assess their advantages and disadvantages, with reference *inter alia* to the rights and dignity of man and other moral values."

However, when we pass from the declaration of principles to individual questions and problems we come up against conflicts and differences of opinion which appear irresolvable. We need only think here of abortion, artificial and assisted fertilization, euthanasia, the use of embryos in scientific research, of the very many instances of conflict between personal and collective interests, and between the life of one individual and another. The bioethical debate thus moves from special and particular questions to basic philosophical issues. Answers to these issues could be looked for in other spheres of thought where they have been debated for centuries, but biology now feels itself mature enough to make its own independent contribution, not least with reference to an astounding quantity of information which the discipline itself has been able to accumulate.

2. The Centrality of Life

What is life? This is the first question to which the biologist seeks to give an answer. For him, life is the light which illuminates the universe and gives it form, thereby bringing it out of the darkness. The reality which surrounds us does not correspond to an objective fact but is the outcome of the perception which living creatures have of it. In some of these creatures sight is the primary sense, in others it is taste, touch, hearing, smell or other systems which are not present within man or which have become atrophied. Reality changes completely according to which sense is dominant. One type of food can be pleasant or unpleasant, an object can be dull or full of colors, an event can be a source of joy or of desperation, and what is invisible for one creature can have major consequences for another.

There is also a reality which is constructed by instruments created by man, and this goes well beyond the domain of the senses—towards the ever smaller world of cells, molecules, atoms and particles, or to-

wards the ever greater world of stellar space. Time also changes according to the individual or, in the same individual, in relation to his biological age. There is the time of childhood which is so shaped by the experiences the individual undergoes as to seem eternal, but there is also the time of the old person which flows away with ever greater speed as the events which interest him become rarer and further and fewer between.

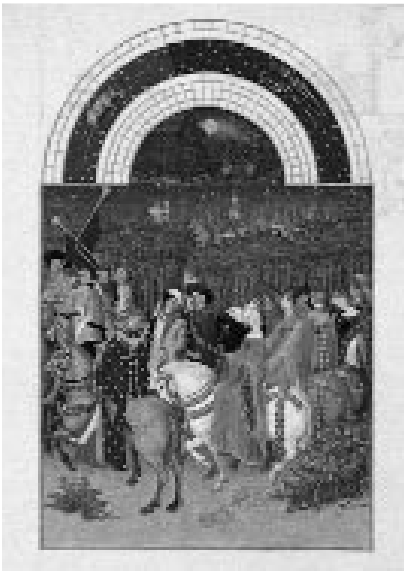
There is the reality which is limited by the speed of light. Yet today we can already imagine that one day when we will enter that reality through an instrument which can detect the superforce which sustains and invests the universe, not travelling in space and time like light but linking them together completely like an elastic band which is always tight. There is also the universe of the microbes which extends for a few millimeters and lasts for a few minutes but which is as real and as lasting as the universe of man. What gives us the right to consider one of these realities as being more real and tangible than another?

These ideas have been the object of sustained debate by philosophers, who have always oscillated between relativism and objectivity in their search for a fixed point of meaning. Thinkers have also been concerned with the theories of physics regarding relativity and indetermination, theories which seem to be more advanced because they are proved by experimental methods but which are not able, however, to include life or man in their equations. These ideas are now the objects of discussion in biology, a discipline which places life at the centre of the universe.

The sacredness of life thus becomes not only a religious idea but also an idea beyond the religious sphere, and the biologist feels like a climber who reaches the top of the mountain after a great effort only to discover that somebody else has got there before him, and by another route.

3. The Essence of Life

How does life function? This is another fundamental question for the biologist and it is strictly linked to the first. According to the laws of physics, the universe is upheld by a force which pushes each and every thing towards the loss of organization and order,and towards an increasing level of entropy. It is like a glowing ember which is becoming burnt out and turning into ash. Life is a part of this universe but it goes in an opposite direction and towards configurations which are characterized by an increasing degree of order and organization. It is like a sailing boat which follows a precise course and in the face of a violent wind gradually manages to go in a direction which is a diametrically opposed to that taken by other things which, for their part, are blown onto the rocks. Life can do this



because, and only because, is it different from the rest of the known world.

Life bears the knowledge of its own identity and defends it against everything which seeks to destroy it; it also constantly develops that identity. Knowledge—that is to say an organized and organic complex of information—is not, therefore, merely that which through life gives origin to surrounding reality: it is also the core of life itself.

Rather than explaining this mystery, the discovery of DNA acted to increase it. This discovery showed that the project of life is present in every living thing in addition to being present in each of the billions of cells which go to make up multicellular organisms. In an infinitely small space which is invisible to the naked eye, is to be found the essence of life itself: its past, its present and its future, in all their forms of expression, from the most elementary to man himself.

DNA has been called the project of life (Dulbecco) but this term is not adapt—a project on its own remains a dead letter if their is no external action on the part of its formulator. The project of life, on the other hand, "contains within itself everything which it needs to come to fruition, except,naturally enough,the basic matter and the energy which it gains from the environment. It knows how to construct of its own will the pieces which it needs and the instruments which are required to put these pieces together. It knows how to adapt to the environment. It knows how to create sub-projects which become ever more detailed in character and are required as the project progresses. In addition, the project of the living being and the living being which springs from that project are not separate but strictly identified with each other. Rather than "project," therefore, it would be better to use the term "Sacred book of life,"for this enables us to express that feeling of bewilderment which we feel when we try to turn over its pages." (Silvestrini, 1995).

This project is the essence of life throughout its journey, from simple duplicative procreation to sexual procreation and then on to cultural procreation. It happens before our very eyes every day when a single fertlized cell divides into two, into four, into eight, into sixteen, and so forth, and from this myriad of components there emerges in distinct form the embryo, the foetus, the newly born child, the infant and then the adult. The adult has already begun the downward path but not before giving his particular contribution to life. The project also carries within itself future developments, those developments which will lead it to spread out even further through scientific and technological progress.

We do not need to be Einsteins to understand that at the helm of the sail boat which tacks against the wind there is something which is different from the sea in the midst of a storm. For the nonbeliever this *quid* either remains a matter of mystery or is seen as the mere outcome of chance, the fortuitous combination of billions and billions of events which are constantly taking place in the universe. For the believer, on the other hand, there is the idea that transcendental action is at work.

Once again, however, the divergence between religious thought and

nonreligious thought loses importance because life exists anyway and constitutes everything that we have. Both schools of thought, therefore, can but agree on the basic principle of the defence of life. To quote a document of the National Committee for Bioethics: "the defense of life is not rooted in an abstract form of philanthropy but in the recognition that man exists because he is a living being and that he is at the same time endowed with his own specific individuality which renders him unique and means that he is closely interconnected with the society to which he belongs" (National Committee for Bioethics, 1995).

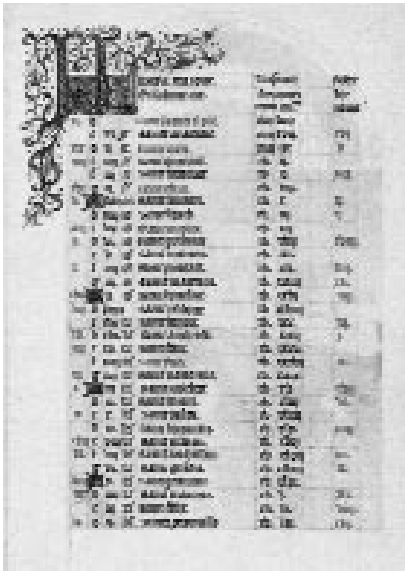
4. Life Is Progress

Every other living being adapts to the fundamental principle of the defence of life because of the very fact that it exists, and this thanks to the information present in its functioning and its organic structure, this latter being composed of different kinds of apparatus, organs and minor organs. In contrary fashion to what happens with the books of man, this information is present in the form and the functioning of life, and it is the same thing. This concept is partially expressed in the chemosmotic theory of the interdependence of form and function, a theory which gained for Mitchell the Nobel Prize in 1979 but which clearly has a far wider value.

It is to be found in the whole of the evolutionary process and was described in the bible for those who know how to read it. During the evolutionary process life gradually passes through single cell organisms to multicell organisms which place themselves in the hands of survival instinct and give their bodies special forms of apparatus—integuments which protect them against harmful radiation or bad weather, fins or gills to move and live in the water, wings to fly in the air, and so forth. The information concerning these changes is not written and kept to one side in a library, but is contained within life itself.

Man has these characteristics as well but with him something new happens. Rather than allowing himself to be guided instinctively by the fundamental law of life, he analyzes it and tries to find a rational explanation for his own existence. Rather than waiting for his integuments to adapt to bad weather, or for fins and wings to appear on his body, with his own hands he builds clothes, shelter, boats and planes.

He also creates instruments and tools which help him to extend and enlarge his knowledge and thus to do the same to that universe which exists beyond the domain of his senses. This change springs from his manual and intellectual capacities which enable him to draw information about life from its natural substratum and then transfer it to another substratum made up of spoken and written language and of



collective and individual culture. He translates it, therefore, into practical means. It seems, but such is not the case, that he takes on the ideas which Plato attributed to the divine.

This is the starting point of a new type of evolution which comes to be called progress. It is a part of life and it promotes its development but it also concentrates in the hands of man an enormous power which makes him proud of himself yet also frightens him at the same time. If he is religious he feels the bearer of a divine mission but at the same time he is afraid of breaking its rules. If he is a philosopher or a scientist he pursues knowledge, but paradoxically the more he advances the more he feels incapable of giving an answer to these fundamental questions.

If he is an ordinary man he gains from the benefits of progress, benefits which prolong his life and make it increasingly comfortable. But he also becomes frightened when he considers the risks and the dangers which accompany that progress.

5. A Lesson of Life

The answer to these questions is to be found in those same intellectual capacities which have made progress possible. Differently from other living creatures who defend life instinctively merely because they exist, man is able to understand the fundamental principles of life, to achieve wisdom in relation to life, and thus to respect it not merely instinctively but also consciously.

Thus it is that culture stops being a theoretical lucubration and gives practical answers to the questions with which man is bombarded both in the details of his daily life and in the more general political sphere. Some achieve this advance through the gift of faith—the quickest path but also the most difficult. Some others advance through studying life with humility. I firmly believe that both these paths can converge. Indeed, life communicates the same teachings as those imparted by religion. Respect for the rules of civic co-existence derives primarily from what is convenient rather than springing from an ethical imperative. There is an opportunity to be at the same time both egalitarian and aristocratic because life entrusts a specific and complete project to each living being from the microbe to man, and gives each living being an equal point of departure.

At the same time, however, it gives a prize to the being which emerges because of its quality or commitment. It does both these things because the individual is certainly appreciated for his quality but this is only because he belongs to a community.

This is why the Church could never be left-wing or right-wing, Liberal or Socialist, but always both. Life does not pursue pleasure or fight pain in themselves as man might be tempted to do. It uses both these phenomena to give an indication as to what is harmful and what is useful.

For life everything which exists has a meaning where it forms a part of its project. In this sense every authentic culture, whether based on religious belief or not, stops being an abstract fact and transforms itself into a lesson for life.

6. Respect for Life in Biomedical Research

I am not a philosopher. I thus leave to others the task of developing these ideas in a way which is suitable. It falls to me merely to emphasize that these ideas can be applied in extremely practical terms in the realm of biomedical research as well, and let us not forget that biomedical research has become one of the most important elements in promoting progress.

I will not dwell here upon the areas where biomedical research has involved degeneration and degradation by offending life rather than respecting it. I will concentrate instead upon those two paths which it has always taken in the achievement of positive results. The first path has led it to fight suffering and illness from the outside. Here biomedical research has achieved very great successes which have improved the quality and length of human life.

But these successes have turned out to be ephemeral. One need only think here of antibiotics. They represented one of the most significant stages in the advance of modern medical treatment. But perhaps precisely for this reason it was forgotten that during evolution the defensive mechanism of antibiosis was diminished in importance and greater emphasis was placed upon the role of the immunity system which was, indeed, much more effective. We were thus unprepared for difficulties which arose in the use of antibiotics, difficulties which could have been easily foreseen: bacterial resistance and thus the constant employment of new antibiotics; side effects which constantly take on new forms; and the great problem of those millions of children in Third World countries who were saved but then abandoned to inhuman conditions in which to live.

The other path involves studying illnesses before fighting them and examining not only their causes but also their biological significance, their interrelation with other processes, and the defensive mechanisms produced by nature herself to combat them. This path offers more long-lasting and secure solutions: vaccines, health education, the development of health structures and services, action to defend the environment, and social organization.

Respect for life, therefore, means first and foremost a thirst for knowledge. This idea shines forth from the words of all those great scientists who have contributed to the advances and successes of medicine, including my teacher and guide Daniele Bovet (Bignami, 1993). But going back even further in time it is an idea which is powerfully present in the teachings of Hippocrates. And it for this reason that I feel I should express my gratitude to, and admiration for, Cardinal Fiorenzo Angelini, who, in dedicating this conference to Hippocrates, has given us a very valuable opportunity to meet each other and to engage in shared reflection.

I have tried to develop this concept from a philosophical approach, and because such a point of view is rather unusual for me I will have undoubtedly fallen into error, and for this I ask forgiveness. I have also adopted this approach because I am firmly convinced that fundamental religious principles have a universal value and can be reached through paths which do not involve faith. This is a way of understanding the motto *non prevalebunt* and it is also the element which leads the believer never to fear debate and the exchange of opinions with those who do not share his religious opinions, even when very strong and opposing feelings are involved. For this teaching, as for others, I am indebted to Cardinal Fiorenzo Angelini, in the same way as I am indebted to other Princes of the Church who bear witness to this teaching in their works before they give expression to it in their words.

Professor BRUNO SILVESTRINI
Director of the Institute of Phamacology and Pharmacognosy at La Sapienza University, Rome
Consultor to the Pontifical council for Pastoral Assistance to Health Care Workers

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CARLA GIULIANA BOLIS

The Human Brain: from Hippocrates to the Present Development of Neurosciences

The search for a coordinating system and localization of functions in the nervous system and in the body was always given prime importance in anatomical studies and in the philosophical approach over the centuries.

Sometimes information, even linked only to macroscopic events, was not interpreted as particularly fundamental as it was later considered. But we have to note that the understanding of the brain's functions is only nowadays considered correctly.

The study of the brain has required a lot of scientific achievements and technical skills and we can say that only now we are in a position to understand the basic mechanisms of most of the physiological and biochemical functions linked to the nervous system.

A clear example of the difficulty of interpretation is given by the discovery of an Egyptian papyrus, dated 3000 years BC, in which there was a sequence of observations of head injuries correlated to specific somatic manifestations. In principle, the observation were correct, but it took almost 50 centuries to prove the basic mechanisms of the correlation between head injury and peripheral lesion.

We have today to begin considering the work of Hippocrates. there is no doubt that Hippocrates (460-370 BC) was a great physician and also had a very clear understanding of some neurological conditions like stroke and epilepsy, which are mentioned in the *Aphorismi* and the *Praesagia Hippocratis, liber II, De convulsione.*

Hippocrates and his school, in the publication *Corpus Hippocraticum* introduced the rationalization of the events that lead to diseases. No more divine intervention was described.

The vision of Hippocrates and of the philosopher Plato (429.347 B.C.) concerning the localization of coordination was somewhat cerebrocentric, but later Aristotele (384-322 B.C.) imposed his cardiocentric view of coordination of the human body. Aristotele described the heart as responsible for all the functions, including perception and thinking; the brain was the coldest part of the body and its function was to temper the heat generated by the heart.

Herophilus and Erasistrato in the third century B.C. had been able to study human bodies and they had been in a position to distinguish cerebellum, brain and medulla. They also demonstrated that the brain has ventricles and that its surface has circumvolutions. In addition, they clearly understood that blood vessels are very different from nerves and the origin of nerve is brain or medulla. Nerves are distinguished between motor and sensorial.

In the second century A.C. Galeno (129-199) disputed Aristotle's view and, through direct observations, he proposed the distinction of motor and sensory nerves attributing importance to the perceptions, thus anticipating the concept *Nil est in intellectu quod prius non fuerit in sensu.*

Galeno considered not only anatomy but also was the first to look at physiology. He gave great importance to the ventricles, which he divided into anterior, medial and posterior. Galeno also predicted that along the nerves travels an agent, the pneuma. His intuition was left aside for at least two thousand years when the electric communication was discovered along the nerve.

Specific concentration of studies of the brain has been given by Emeso, Bishop of Emesa, and St Augustin in the fourth century AD, concerning the localization of function to the three ventricles described by Galeno: in the anterior ventricle is localized imagination; in the median, reasoning; and in the posterior, memory. This is the first approach to localization of function, and for almost a thousand years this approach has given rise only to drawings and prints.

At the time of the Renaissance anatomical studies continued and at the Hospital of Santa Maria Nuova in Florence around 1505 Leonardo da Vinci took wax mouldings of cerebral ventricles and made drawings of the brain's circumvolutions. Around the same time again in Italy Vesalio, and in France Fresnel, gave more and accurate morphological descriptions.

Willis (1667) tried to find a more accurate anatomic description and he distinguished the brain matter, i.e., gray and white. Willis, taking into account the work of William Harvey (1578-1637) on the heart and circulation, conducted brilliant studies on brain circulation, for the identification of the *rete mirabilis* or Willis circle.

But during this period brain research, considering the relation between brain, mind and soul, took a philosophical approach.

In 1665 Malpighi described, in *De Cerebro Cortice*, the brain surface with a primitive enlargement system. In 1666 in the *Cerebro* he described two observations on the

distribution of the gray matter in the brain. He stressed the structure of the brain being particularly difficult to dissect; the manipulations that he had to make naturally gave rise to a series of artifacts.

Around 1718 van Leuwenhoeck produced the first appropriate imaging of the microscopic organization of the nervous system, when he considered the structure of the nerve as composed of little vessels reassembled together, sometimes envelopped by a structure later identified as myelin.

Microscopic anatomy did not make progress until 1824 when Dutrochet identified, in invertebrate ganglia, the presence of "little cells" of spherical form. This is the first description of a nervous cell. A few years later, Valentin described the presence in the cerebellum of tails around these spherical cells and we know now that these tails were later identified as dendrites.

Finally, Deiters (1865) proposed the structure of the nerves as we know it today, thanks to the introduction of electronmiscroscopy (1950).

In the framework of these observations and Deiter's proposal there was, in the scientific community, active thinking about the possible communications and interactions between the nervous cells. Today we know that interactions are restricted to specialized systems called synapses. This word comes from Greek, meaning "clasp", and was coined by Charles Sherrington (1897), and in one of his scientific contributions he wrote: "So far as our present knowledge goes, we are led to think that the tip of a twig of the arborescence is not continuous with, but merely in contact with the substance of the dendrite or cell body on which it impinges. Such a special connection of a nerve cell with another might be called synapse." Already, 50 years before (1850), Claude Bernard had maintained the possibility that the contact between nerve and target cells was specialized and some change had to occur during the transmission of the signal.

At the end of the nineteenth century and beginning of the twentieth century there was an interesting debate on how neuron connection is established. The provision of a better system of staining (silver staining) nervous tissues was discovered by the Italian, Camillo Golgi, and also applied by the Spaniard, Santiago Ramón y Cajal; together with better techniques of microscopy, these led to formulation of the neuronal versus the reticular theory. Of course, the neuronal theory considered the neuron as an individual cell, already distinct in space from its target cell and affirmed the individuality of the neuron. However, upon this dispute, in which the neuronal theory won, followed another

debate: How the signal given by the neurons was transmitted: "chemical transmission," according to which neurons were supposed to release molecules acting on specific cells, or "electrical transmission," according to which the signal was of an electrical nature.

It is really interesting to note that in 1884 Thudicum published *The Chemical Composition of the Brain*. At that time, biochemistry was starting to emerge, but no valid techniques for correct identification of substances were available. We have to wait until the turn of this century, and only in the 1950s the chemical composition of substances was identified.

The research work of Sir Henry Dale and Otto Loewi finally established in 1920 that the chemical transmission was the most valid theory. But at that time all the sequence of events involved in the generation and propagation of the electrical signal were not yet known.

It was only in 1786 that Luigi Galvani, making experiments on frogs, proposed the existence of a kind of animal electricity. Later, in 1838, Matteucci registered for the first time the electric current produced by a muscle. In 1898 Dubois Reymond described the existence of a current that travelled along the nerves. In addition, in 1875 Caton demonstrated, in experiments on rabbits, that the cerebral cortex also produces electricity.

The magnificent publication of *"De viribus electricitatis in motu musculari commentarius"* by Galvani in 1791 opens an important and fascinating approach to animal electricity.

Until 1950, there was no evidence on how stimuli could produce nerve excitation. Today we know, thanks to the studies of Hodgkin and Huxley (Hodgkin, 1964; Hodgkin and Huxley, 1952; Hodgkin and Keynes, 1955) that the execitable membrane exists in two states: one polarized (with the maintenance of different ionic changes on two sides of the membrane) and one depolarized, which results from the former following drastic changes in permeability, an order of milliseconds, after stimulus.

The rapid changes in ions permeability give rise to the electrical impulses transmitted along the nerve axon, where ion exchange is regulated by the plasma membrane through which the cell communicated with its environment. The axon offers a unique pathway not only for the conduction of ion impulses but also for the circulation of macromolecules between the central nervous system and the peripheral organs. Any interruption or pathological alteration of nerve fibers impedes the axonal transport of molecules and thereby deprives the central and peripheral parts of the nervous system of molecular exchanges.

This axonal anterograde transport is one of the central issues that facilitate the understanding of physiological mechanisms responsible for axonal degeneration and regeneration. Vice versa the retrograde axonal transport represents the means by which chemical information is conveyed from the axonal periphery and possibly from the target

cells to the cell body. Such mechanisms may play an important role in the regenerative response and in the development of stable synaptic connections between neurons and their target cells.

At that time the structure of the biological membrane mechanism was well defined, and the studies on transport systems were very active.

In view of the ability of CNS and PNS to repair after exposure to different environmental conditions, and to establish new adaptive connections, or recover function through involvement of surviving neurons, neuronal recognition is now a very promising field of research, especially for its impact on nervous lesions and repair.

Today we know that the human brain is composed of about 10.11^{11} neurons, a number very similar to the stars in our galaxy. These cells are subdivided in 100 different cell types, whereas in all other organs of the body the subdivision is rather modest.

In this cellular complexity, functional effectiveness is reached through harmonius cooperation. Cooperation is maintained by the genetic code, neurotrasmitters, neuromodulators, and neurohormones and is expressed by neuronal functioning and behavior; inefficiency of these related activities is expressed by pathological conditions.

Even if nervous system cells are linked to the same genetic coding as other cells and have a general cellular organization, they differ from other cells in some characteristics, especially because these neuronal cells interconnect and function with other cell types making specific contacts with other neurons, gland, or muscle cells.

The communication is by electrical and chemical signal via synapses. Chemical signals are related to neurotransmitters: first, T.R. Elliot, on 21 May 1904 at the meeting of the Physiological Society of London, stated that “adrenaline might be a chemical stimulant liberated on each occasion when the impulse arrives at the periphery....”

The chemical and the electrical transmission is that at the contact wone between two nerve cells; the chemical signal (neurotransmitter) is released under an electrical signal at the pre-synapsis and recognized by post-synaptic receptors, leading to the modification of the biological activity of the receiving (post-synaptic) cell.

The receptor is a protein bearing specialized regions (sequences of amino acids) able to specifically recognize the chemical message. The synapse is an important site of signal modulation and of homeostatic regulation. The release mechanisms and the recognition processes are regulated events. The specialized contact point - the synapse - should therefore be considered as a “plastic” site that can be modified by brain activity and physiological events.

Quite a number of neurotransmitters belonging to several unrelated chemical classes are known today.

Among classic neurotransmitters catecholamines and acetylcholine were first described and are the most studied chemical messengers. These two classes of neurotransmitters represent in several physiological activities an example of functional antagonism.

Finally, we should stress the recognized possibility of the coexistence (and functional cooperation) of more than one neurotransmitter in a nerve terminal.

The receptor proteins are divided into two main categories, the receptors that constitute an ion channel and those that are linked to G-proteins. This leads to the introduction of the concept of the receptor interaction with other membrane proteins, such as the G-proteins, that allow the activation of a final effector system. It is a cascade of catalytic events allowing the amplification of the signal.

The interest on G-proteins has been growing, as witnessed by the recent Noble prize given to Gilman and Rodbell for their discovery. The G-protein is the protein connecting the receptor to the effector. Several G-proteins are known to depend on the cell type and transduction system involved. We should note the existence of both stimulatory and inhibitory G-proteins that converge on the same effector system, leading to the strict control of the amount of information to be transmitted.

Finally, we should recall the importance of the phosphorylation systems, which are either built into some receptors (e.g., receptors for growth factors) or linked through the already described cascade of events to the activation of several receptors (e.g., receptors for biogenic amines).

To all this information should be added the recent notion that specific neurotransmitter systems, such as those containing VIP and NE, as shown by P.J. Magistretti, may regulate metabolism in glial cells and in endothelial cells of intraparenchymal vessels of the brain, adding a previously unforeseen function for neurotransmitters.

The search for the localization of functions in the brain was always at the forefront. To this end, Franz Joseph Gall produced the following experimental data at the end of the nineteenth century. He made ablations of well-defined anatomical, centers and observed animal behaviour.

For instance, he demonstrated that the abation of cerebellum disturbed coordination of movement. In addition, in agreement with Galen he demonstrated that bulbar lesions (at the posterior ventricle) induce modifications in respiration.

Later, Gall considered that verbal memory or language was located in the frontal lobe of the cortex. The French neurologist Bouillard, over 40 years of study of 100 cases, put in evidence that there was a linkage

between brain damage in the frontal lobe and loss of speech (1825).

But it was only in 1860 that the neuroanatomist and anthropologist, Broca, presented his clinical and anatomo-pathological evidence that language loss is related to unilateral damage of the left frontal lobe. He demostrated at the same time the asymmetry between the hemispheres. Also very interesting were the studies of Carl Wernicke in his monograph of 1874 on "Der Aphasische Symptomencomplex."

In 1909 Brodman assembled all available data on men and monkeys and divided the cerebral cortex into 50 areas: areas of association, of motor or sensorial perception.

It is only in the last two decades that tools have been developed to accurately localize brain function. These tools include CT scan, PET, SPECT, magnetic resonance, and others.

Today we understand many activities of the brain, including energy utilization and function. Of course, these techniques have been conceived for the diagnosis and understanding of basic mechanisms underlying neurological and psychiatric disorders.

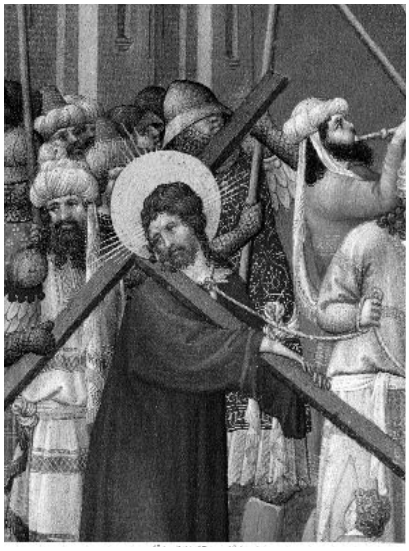
All approaches and applications of new techniques since the early stages of man's interest in the brain, as a site of control of body functions and of the mind, have been crucial for today's understanding. The success of neuroscience depends on a multidisciplinary approach: biology, anatomy, physics, chemistry, and medicine.

The use of drugs (neuropharmacology and psychopharmacology) has also been fundamental in the understanding of specific function-affecting neurotransmitters, second messengers, plasticity of synapses and neuronal circuitry. Through molecular biology it has been possible to define the structure of some of the receptors, especially the complex protein receptors and ion channels.

The application of molecular biology has been crucial for the identification of several genetic diseases in neurology and psychiatry. The information available in basic neurosciences has been essential for the identification of basic mechanisms for the prevention and treatment of nerve degenerative disorders due to environmental toxins, metabolic causes, and infectious agents.

Today we know that glial cells, the non-nervous cells in the nervous system, are fundamental for the maintenance of the functional activity of neurons and axons. The integration activity of neurons and glial cells regulates many of the neuronal activities and, according to new experimental studies, participates in the regulation of cerebral metabolism.

But basic research transcends the laboratory and extends into all areas



of human behavior. What commenced as an anthropological study of an isolated tribe in New Guinea, afflicted by a progressive degenerative disorder of the nervous system, opened up a whole field of investigation demonstrating that some chronic neurological disorders are caused by persistent viral infections.

Anyway, today, using the rational approach to disease indicated by Hippocrates, we are able to prevent and control a series of neurological disorders, and this list is likely to increase in the near future.

CARLA GIULIANA BOLIS,
M.D., Ph.D.
Professor of General and Comparative Biology, University of Milan (Italy) and Consultant, WHO Unit on Neuroscience

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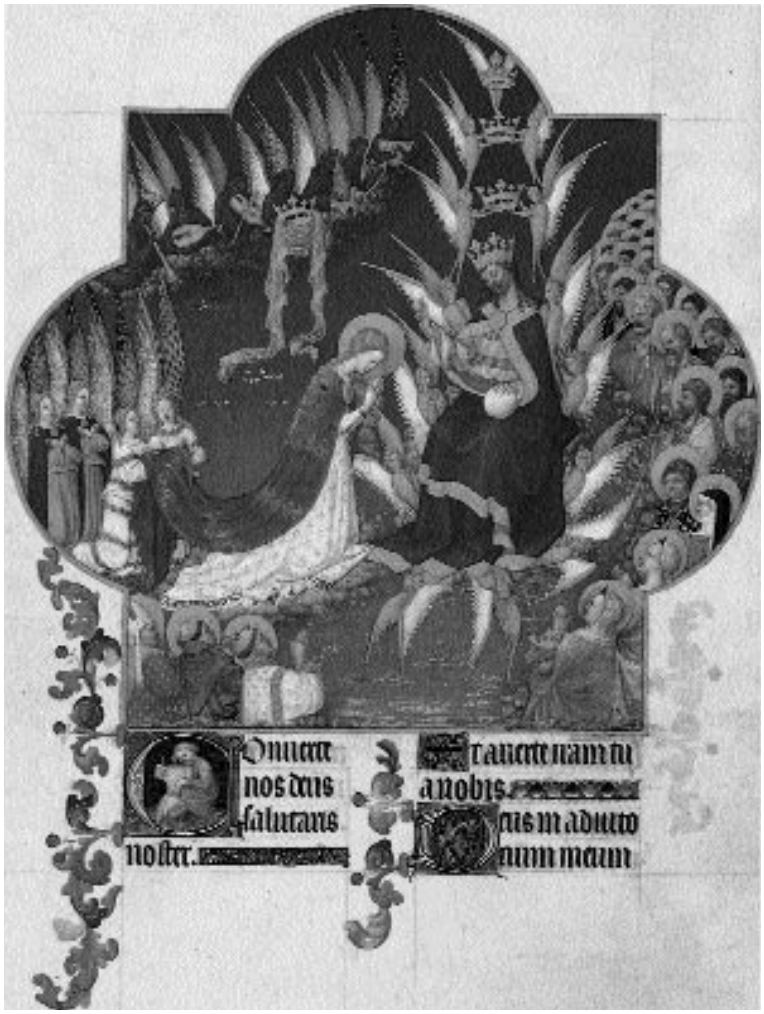


CETTINA MILITELLO

The Overcoming of Emphasis on Pain in the Christian Conception of Suffering

1. Pain and Suffering as Anthropological Aporias

Pain and suffering have always accompanied the individual and he has often not been able to respond in adequate fashion to the dramatic reality of the questions they pose. This, in the ultimate analysis, is because the problem they present is the same as that of the meaning of man, his limits and the reason and the meaning of these limits. Whether as appeals to nature or appeals to a transcendent divine force, man experiences suffering and illness, and above else death, as an "evil." Keen to rise above himself, in search of immortality and lasting happiness, he seems unequal to the experience of pain, to which, however, he strives to give an answer.

"In the cultural repertory of every human group there exist theories about illness, whether of a scientific or religious character.... They are as variable and as various as the cultures to which they belong. No theory can be fully understood outside the cultural context to which it belongs and the social structure of groups which share certain opinions and strategies in relation to adaptation and survival."[1]

Pain, suffering, illness and death, therefore, involve the anthropological subject, whether the individual person or the collective personality. They interact, that is to say, with the specific characteristics of the subjects and with the social group as such in the latter's understanding of itself as a cultural entity.[2]

For the so-called "primitive" peoples and cultures, at the origin of every form of suffering, and of every calamity or catastrophe, there is a transcendental power of which man is the victim. For Greek culture as for Jewish culture, pain, suffering and death have their roots in personal responsibility. In our century Marxist culture has condemned social conditions and their impact, while psychoanalysis has referred to the influence and impact of the subconscious.

Whatever the response or the specific approach may be, in our culture the drama of pain still remains completely open.[3] This is all the more serious in its implications because we are now face to face with a sort of collective removal of everything which might disturb the general mind. This reality is rooted in the establishment of a model of life which is hedonistic and consumeristic to the extreme.

Perhaps our culture has ended up by succumbing to all the consequences of that removal of myths and the sacred from our approach to nature which according to Max Weber had its point of departure in biblical religion and the reality of "disenchantment," something which involved an approach to nature which contained an operative intention, which in its turn was an essential preliminary condition to the development of the scientific mentality.[4]

Whatever the case, within our culture and its collective processes of removal there is the perverse and titanic wish to defeat illness, pain and death, and this is something which is almost equivalent to a delirium of omnipotence. There is the tendency to interpret pain and illness as alien phenomena which arrive from outside and remain extraneous. This idea is almost certainly further encouraged by the practical expression of the methods of medicine.[5]

In our culture, therefore, pain is seen less and less as a "human" experience. This is particularly disturbing when one considers that the anthropological subject presents itself as an ever more complicated reality and does so no longer in the partial perspectives of the sciences of nature but in the global perspective of the human sciences and their organic correlation. At the heart of their outlook these latter place the human phenomenon in all its global predictability, in its psychological complexity, in the grid of its self-understanding, in its shared interaction with other human subjects, and in its historical location within the many-faceted story of the world of created beings with which its existence and the existence of others is bound up.

However the paradox of the delirium of omnipotence which exorcizes pain and death lies in the anxiety which afflicts the man of today without giving him rest. A fleeing from the ultimate question of meaning does not remove "existential frustration,"[6] the inadequacy or the senselessness of being in the world without an answer which reveals man to man (cf. Gs 22). The problem, therefore, is anthropological in nature, and for believers it is also, and of necessity, theological. We have, therefore, to return to the answers that the Holy Scriptures[7]—both the Old Testament and the New Testament—give to the problem of pain. What we have to do, is (and in all honesty) return to the interpretative paradigms which have been offered by Christianity during the course of its history.

2. Paradigms of Theological Solutions

2.1. The Old Testament and the New Testament

The etiology of Genesis responds to the meaning of suffering, pain and death by making humans re-

sponsible for them. The God who called the universe into existence, the God who created male and female man, is a wise and just God. Neither death nor pain are his work, and at the same time there is no other God than He. Suffering and death are, therefore, the work of man and of his sin.

Despite this guilt, man is not abandoned by God. The Creator is also the "redeemer." Indeed, it is from the experience of redemption that biblical man moves in relation to the intelligence of the plan of the Creator. The optimal horizon of biblical man is always *"shalom,"* that blessing of God which is expressed in security, well-being, and immediate and practical happiness.

In contrary fashion illness and pain are a punishment in proportion to guilt. But as the Book of Job—an authentic *summa* on the mystery of suffering—reminds us, not everything is always so simple and obvious. But whatever the case may be, in the victory of faith over trial and tribulation Job is returned to that condition of happiness and well-being which should characterize the existence of the righteous man.

Although it is true that according to the revelation of the Old Testament the God of Abraham, Isaac and Job is a God of life, we should not, however, minimize his capacity to be moved. The God of the Covenant suffers because of the sin of his people. He speaks to it in dramatic terms. He complains about its infidelity, its adultery. He expresses his passion for the people he has chosen with expressions which bear the human experience of betrayal, abandonment and faithlessness. This emerges above all else in prophetic revelation,[8] in the dialogue which He sustains with those members of this people whom are called by him, almost with violence, to act as channels for his impassioned love.

Thus it is that beyond the interpretative framework which attributes death and pain to the sin of individuals or the whole of Israel, beyond the disturbing paradox (and indeed notwithstanding) the prosperity and happiness of wicked men and the unhappiness of the righteous, the God of Israel is a God who suffers, who feels anger, who is moved, who is able to take part in, and to take upon himself, the suffering of his people.

The God of Israel is also a merciful God who through suffering and punishment invites his people to change their ways, to turn to Him, to return to loyalty, to his love and to his law. Suffering and trial thus become a *"crisis,"* a test, a perception, an opportunity offered anew to return to his love and his covenant.

The "pathetic" aspect of the God of Israel becomes emphasized and where possible more explicit and definitive in the New Testament. Here the Word made flesh shares and takes upon itself everything, including suffering, which belongs to the human experience. The *"kenosis"* of the Son of God (cf. Ph 2:7)

includes being born to a woman (Gal 4,4); being subject to the laws of growing up (cf. Lk 2:52); having to draw away from his natural family (cf. Lk 8:19); the experience of being rejected by those who are nearest to him (cf. Lk 4:28 ff); by his people in both a wide and a narrow sense (cf. Jn. 6:60 ff; 12:37 ff); and by his disciples, those who he personally called to him and who endure the scandal of his passion and death (cf. Mt 26:69-75; Mk 14:50). Jesus suffers and is moved in individual terms. He is wounded in friendship (cf. Mk 14:10-11), and in love for his city which is destined to be ruined (Lk 19:41). But above all else he bows before the suffering of others and uses healing as a call to the values of the kingdom of God, the path to faith and conversion (cf., for example, Jn 9).

The Son of God experiences violence and death through his own flesh. He is frightened of them like any other human creature. in the solitude of Gethsemane (cf. Lk 22:39-44) and on the cross (cf. Mk 15,34) pain and death seem to him to be without meaning. But it is in this participation in the meaninglessness and scandal of pain, which afflict him because he has made himself "sin" (cf. 2 Co 5:21), that the passion of God for man reaches its culminating point. In this passion is revealed the final redemptive plan: "Christ has risen from the dead, the first fruits of all those who have fallen asleep" (1 Co 15:20).

The event of Christ does not exorcize pain, it does not remove it from the human horizon. But for the believer the reference to Him is paradigmatic. Victory over death and pain takes place through participation in his *"kenosis."* But it is precisely in this horizon of participation, in this imitation of the *Christus patiens* and of the "suffering servant" that Christianity sets out two ways of understanding pain which are different and antithetical.

2.2. Christian Culture and the Experience of Pain

On the one hand Christians have laid stress upon the mysterious relationship which exists between faith and the cross. They believe that the price of suffering is infinite when it is associated with redemption. Spiritual authorities, and above all the "moderns," have concluded from this that suffering is absolutely necessary to inner progress. It has even been argued that only suffering brings the impress of authentic perfection and that because of this we should want to experience suffering and love suffering. It is certainly true that nobody has ever argued that suffering is a good in itself, a good unrelated to the love of God. But a great many works of devotion have over the centuries implied such a doctrine.

There is, however, another and opposing school of thought, which is more moderate and more plausible, and certainly more rooted in the tradition of the Gospels and the Fathers. The idea proposed by this school is that suffering derives from evil. God, it is suggested, wants us to struggle to extirpate suffering from this world to the greatest extent possible. The establishment of the joy and the peace of the Lord, the promotion of the kingdom of God on earth—this undertaking is more

in tune with humanism which at another level strives to promote development and natural good. The defeat of sadness through the illuminating effect of a love which consoles us is a heroic and courageous undertaking. However this ideal, like that ideal outlined above, can lead to erroneous doctrinal emphases which can provoke, even though indirectly, a diminution in the value attributed to the spirit of sacrifice.[9]

2.2.1. Praise of Suffering

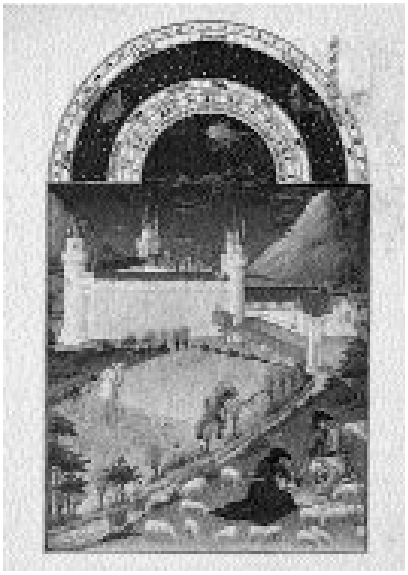
The first approach, obviously enough, is based upon the example of Christ's taking of suffering upon himself, and that only through a personal association with this action does the mystery of pain acquire meaning. This is an idea which is already present in Col 1:24 where Paul declares that he completes within his own flesh what was absent from the sufferings of Christ to the benefit of his body which is the Church. Here there is no suggestion that there was something lacking in the experience of the cross. Indeed, the idea rather is that there is a gaining of individual access to it, a personal entering into the vital dynamic of that body which Christ obtained through dying on the cross (cf. Eph 5:23-26).

However, this principle is full of debatable elements. It has informed what could be termed "pain-centeredness," that forte of a great deal of spiritual literature, but first and foremost something which is the expression of a specific set of cultural circumstances.

In replying to the question of whether suffering is always a good thing, or at the very least if it can become such, it is not difficult to affirm that pain is not always tolerable[10] and that faith is powerless to discern its meaning.[11] The only forms of suffering which can help us are those and only those which can be borne. Unconnected to love and faith, suffering produces only evil. The force and the charity which enable us to face up to suffering are the only elements which are good in themselves. The superiority of the man who has suffered springs from the fact that he was able to prevail over the trial which they imposed upon him.

The identification of perfection with suffering to the point of seeing the first in the search for the second does not appear to be rooted in the paradox of the "suffering servant." His taking of death upon himself on the cross (when faced with other possibilities involving continuing his redemption of man) remains written into the sin of the world. Christ made himself share in the pain of man and took it upon himself, but he did not seek it out for himself. This is demonstrated by his existential travail. Nowhere in the gospels can we find an authentic disciple who is invited to seek out pain for his own benefit. On the contrary, the message of Jesus is a message joyful with liberation (cf. Lk 4:18 ff).

The stress on pain in the history of



Christianity is also accompanied by another emphasis, namely that which attributes the "gift" of suffering to God's initiative. It is to nonbelievers that God appears first and foremost in this form—as the by no means paternal guise of a torturer, something which is in radical antithesis to the teachings of Christ outlined in Matthew 7:9-11.[12] It may well be that such suffering leads to conversion, that it is a unique opportunity for maturation and growth. But an *a priori* exaltation of suffering and the propensity to trace it back at all times to God is without meaning.

The paradox of a Christianity which has made these arguments its own appears in clear fashion if we try to place them in their historical context. We are familiar with the Romantic dimension to "pain-centeredness." But this element was certainly present in previous epochs.

One thinks here of the titanic struggle of the ascetic, the stylite for example. The drawing near to the *Christus patiens* by the martyr is based upon an extreme faith which triumphs over and defeats pain. But the voluntary martyrdom of the ascetic, which is often akin to encratism, is something quite different, and was rightly rebuked by the Fathers of the Church.[13]

The conception of pain during the Medieval period was equally dualistic. A man who is really a man displays indifference and disdain. Pain is a matter for women, as is demonstrated by the condemnation of Eve (Gn 3:16).[14] Nonetheless, physical suffering has a medical value, both as regards the living body and in relation to the soul in purgatory, and for this reason the Medieval imagination produced various forms of correction based on physical endurance.

The almost Stoic attitude towards pain—typical of the feudal aristocracy—breaks up at around the end of the twelfth century.[15] This is connected with a process of declericalization and the popularization of culture which comes to fruition in the fourteenth and fifteenth centuries. Now the piety of the believer is concentrated upon the "Man of Pain," on his passion.[16] He is seduced by this idea and is led to imitate him through physical suffering too, and to make himself responsible for those brethren in whose poor and suffering body the suffering Christ is incarnated.[17]

At times this involves imitation spilling over into the realms of sadomasochism. One need only think of the exaggeration with which the body was attacked, disfigured, and forced to do without food and sleep.[18] In all sincerity, one cannot believe that the mere imitation of the crucified Christ could justify these forms of behavior, phenomena which in more moderate form would remain within the spirituality of the following centuries.[19] One need only cite here the inverse tendency of the Baroque age and the return of the practice of penitence during the seventeenth century, at the margins of the Jansenist movement, the rigors of which developed rather than became arrested within by no means few religious communities, especially for women.

"Pain-centeredness" in the real and authentic sense is a phenomenon which belongs above all else to the last century and in large part to this century, something which becomes

incredible when one considers that it had become extraneous to Occidental culture. Its fatalistic and supine acquiescence in the presence of pain, its propensity to ascribe it in passive terms to the divine will, the search for it as a value in itself, all these elements go beyond the recognition and imitation of the "Man of Pain" as a spiritual paradigm. Indeed, they may even obscure its liberating and redemptive transparency.[20] This is a cultural path belonging to a certain date, and written according to a Stoic or Manichean conception which is not at all close to Christian hope and salvation whose eschatological content blames neither the present and the past nor the experience of the body.[21]

2.2.2. The Struggle Against Suffering

The early Christians certainly ignored the "Romanticism of pain." "Pain-centeredness" was totally absent from their way of thinking and acting. Their struggle in favor of God included every evil, including suffering. This remains the position of all those who fight strenuously against illness and death and make this struggle a part of their human mission and a duty of their Christian witness. I am thinking here for example of Dr. Gianna Beretta Molla who refused to take analgesics in order to remain "compos sui."

In the same way the early Christian community had nothing to do with notions of the providence of pain. The words of the Lord's Prayer "Thy will be done" does not envisage the removal of active individuality, of personal action, in favor of the creation of the kingdom of heaven. What should have been a program of liberation all too often becomes sterile acquiescence, mere blameworthy eschatological flight.

The struggle against suffering does not seek, however, to dull or dim Christian sensitivity and sensibility. It seeks, rather, to tackle the question of illness in coherent fashion by turning its attention to the individual. Suffering and illness are considered with reference to the personal and community sphere.

3. Towards a Christian Conception of Suffering

The publication *"Salvifici Doloris"*[22] paid attention to the subject of human suffering, and perceived in it a salvific value within the context of the suffering of Christ. It is not for us to undergo such suffering again. We are to realize that suffering involves neither disengagement nor surrender. The understanding of suffering, its mystery, which also remains as such from the perspective of faith, does not involve acquiescence in its pathologies, whether physical or moral. Indeed, it invokes the sick person—and here we encounter the paradigm of the Good Samaritan—who in bearing pain takes on a decisive and active commitment.

The individual, therefore, is at stake, the human person, created in the image of God (cf. Gn 1:26). The character of this image, which is not canceled by sin (cf. Gn 5:1b-2), reveals the mystery itself of God in the mystery of man. The mystery of pain can now but find a meaning within that relational impress which manifests the mystery itself of the love of the Trinity in man when he is called to communion.

Man is a *"pathetic"* being.[23] The perception and awareness which he has of himself are necessarily entrusted to the sphere of dialogue, to the request for otherness and transcendence which in revealing him to himself, reveal him for what he is, but always within his ontic limits.

Pain, not in its pathological form but as an awareness and perception of the individual's limits, is an experience which is of the essence of being human. This understanding of oneself and perception of oneself as a man amongst other men within the existential limitedness of a practical being entrusted to a psychophysical complexity, written within time and space, is the horizon, the very modality of the reality of the human phenomenon.

There is a feature of pain which perhaps should not even be termed as such and which is a perception of oneself which is equivalent to an awareness of being limited. But this rather than other realities is man in his psychophysical complexity.

According to the Christian faith, God draws near to this man from the very outset. The Christian God is a God who is aware of the ontic limits of the creature which he has nonetheless created in his image. He draws near to this limit, and even undergoes the experience of death on the cross.

It is certainly true that the Christian faith lays stress upon the conscience, the weight of limitation beginning with the mortgage of guilt. But whatever its alienating and disrupting character may be, the limitation borne by the created being is written into the pre-Fall experience. The problem, then, is to refer to ourselves, in a creative and active fashion, with reference to a God who "suffers" and whose "history"[24] is at the same time the key by which to interpret the "suffering" of man.

Pain in terms of its acceptance as a pathology—which is always and in every way contingent with the subject (illness is not an alien entity but derives and springs from the individual who is afflicted by it)[25]—must be seen in the terms of this original reference point.

In this sense the Christian conception of pain, now that we have removed every uncertainty and "pain-centered" impress, invites the human subject to see pathological pain within the context of ontic limitation. And therefore to live it as a fully human experience and thus commit himself to fighting everything that is a threat to the quality of his life and the lives of other people. This does not mean fleeing from the scandal of the cross but professing the globality of the Christian mystery. This is certainly a mystery of *kenosis* but it is also a mystery of redemption and glory. As has often been observed, Easter Friday without the Resurrection would involve merely the celebration of evil.

It is here and now that we must advance the kingdom of God. It is

here and now that we must return the creation to God, in praise of his glory. It is here and now that we must fight our own limitation, thickened by what we have become used to terming the collective structures of sin.

Between pain as the contextual nature of created beings who exist and pain as evil, as collective and personal disorder, the Christian has no choice but to oppose the second and to see his own limitation as a challenge and an exordial paradigm. We must match up to the merciful *synkatabasis* of God (cf. Dv 8), to represent it as a paradigm for salvation and life and as a *conditio sine qua non* of final access to the Mystery and to glory.

Professor CETTINA MILITELLO
Professor of Theological Anthropology at the Teresianum and Marianum Pontifical Theological Faculties, Rome

Notes

[1] S. SPINSANTI, *Salute, Malattia, Morte,* (NDTM, Cinisello, B., 1990), p. 1136.

[2] Cf. e.g., M. Aug and C. Herzlich, *Il Senso del Male. Antropologia, Storia e Sociologia della Malattia*, (Milan, 1986).

[3] An example of this is *La Douleur. "Au de l des Maux*, (Paris, 1992). This is a brief bibliography on neurology and pain; behaviour and pain; medicine and pain; pharmacology and pain; anthropology and pain; literature and pain. It was an accompanying text for the Paris exhibition of the same title.

[4] Cf. *ibid*., p. 140 ff.

[5] Cf. in addition to the above mentioned work by Spinsanti, e.g., B. HAERING, *Proclamare la Salvezza a Guarire i Malati* (Ospedale Mulli, Rassegna Trimestrale, 1982/692).

[6] The expression is that of V. FRANKL. See his work *Homo Patiens. L"interpretazione Umanistica della Sofferenza* (Varese, 1972).

[7] The time available here rules out an analysis of the extrabiblical, intercultural or interreligious analysis of the paradigms by which to solve the problem and suffering.

[8]. Reference is necessary here to A. NEHER, *L"Essenza del Profestismo* (Casale M., 1984), p. 82 ss. The idea of the "pathos" of God is a notion which Neher takes from A.J. HESCHEL, *Il Messagio dei Profeti* (Rome, 1982).

[9] This is almost a literal quotation from M. NEDONCELLE, *La Soufference. Essai de Rflexion Chrtienne* (Paris, 1950), pp. 12-13.

[10] For the present-day debate on the use of analgesics see, e.g., I. SCHINELLA, "Il Cristiano, il Dolore e gli Analgesici" in *Vivarium*, 3, 1993, pp. 519-531.

[11] The brief apologue of L. SANTUCCI is emblematic: "Pain knocked at the door, it came to open him to faith, but nobody was there."

[12] "Or what man of you, if his son asks him for bread, will give him a stone? Or if he asks for a fish will give him a serpent? If you, then, who are evil, know how to give good gifts to your children, how much more will your Father who is in heaven give good things to those who ask him!."

[13] See my volume *Donna e Chiesa. La Testimonianza di Giovanni Crisostomo* (Palermo, 1985), pp. 74 ff.

[14] It would be interesting to approach the subject of pain from the "female" point of view. It is certainly true that the experience of pregnancy and above all childbirth seem to link women to pain in indissoluble fashion. But today, given that we have removed the idea the women are by their nature weak, the link between women and pain seems an existential paradigm of that "merciful pliability" which enables the woman to rise above herself with a more lucid psyhcophysical lucidity. It should also be observed that the paradigm of the bearer of children as a person able to go beyond suffering was already to be found in the New Testament (cf. Jn 16:21). For a female reflection upon the subject of pain see D. SOELLE, *Sofferenza* (Brescia, 1976) and G. P. DI NICOLA *Il Linguaggio della Madre*, (Rome, 1994). Of equal interest, and rich in literary and iconographic background, is the subject of "mater dolerosa," and this also is a cultural topos prior to being a theological question. (Cf. M. LE BOT, *"Une Femme en Pleurs,"* in AA.VV, *La Douleur. "Au-Del des Maux*, op. cit. pp. 81-94).

[15] The anonymous work *"Le dodici utilit della tribolazione,"* PL 207, 989-1006, is an example of this. Amongst these are listed: the help which God gives to the person in tribulation; the purgative dimension; the payment of the debt incurred through sin; being forced to look for heavenly things; the stewarding of the heart; the assurance that God loves those he punishes...At a poetic level, on the other hand, reference should be made to Jacopone da Todi: "Lord, please," for example....

[16] The experience of Francesco is emblematic here. His loving identification with the "Christus patiens" even implies the presence within the flesh of marks of the passion. If this makes him belong to the imagery of the "Alter Christus" in quintessential fashion, the pre-Humanistic inspiration of Francesco prevents us from placing him within a context which is furtively "pain-centered."

[17] Cf. G. DUBY, *"Reflexion sur la Douleur au Moyen age,"* in AA. VV. *La Douleur. "Au-Del des Maux," op. cit*., pp. 71.79. In his opinion, and because of this cultural mutation, the different attention of science and medicine which gradually commit themselves to the art of healing, reject the redemptive function of pain and dedicate themselves to defeating it with all means available.

[18] A striking example is offered by S. Eustochia, the founder in the fourteenth century of a monastery of Minoresses at Messina. Folk history has it that she engaged in an obsessive search for suffering, and that the mortification of her body led her, after her death, to be a spring of scented oil, a phenomenon which was also present, it appears, in the following century. Cf. F. TERRIZZI, *La Beata Eustochia. 1434-1485* (Messina, 1982). 19. Cf. S. SPINSANTI, *L"Etica Cristiana della Malattia* (Alba, 1971).

[20] This does not mean in the least that we should deny the possibility that such mystical exaltation, inspired by supernatural charity, can involve the expression of authentic holiness and perfection. However there are good reasons for thinking that there is a certain hagiographic tendency to trace holiness to the required stylistic features of "pain-centeredness." Obviously enough, another reading could finally enable us to discover the deep values which have informed the lives of by no means few saints, in addition to and beyond this presumed option in favour of suffering.

[21] On this subject see C. ROCCHETTA, *Per una Teologia della Corporeià* (Rome, 1990) and S. SPINSANTI, *Il Corpo nella Cultura contemporanea* (Brescia, 1983).

[22] AAS (1984)...

[23] On the semantic character of terms connected to pain (pathos/pascho, thlipsis, thlibo) cf S. NATOLI, *L"Esperienza del Dolore. Le Forme del Patire nella Cultura Occidentale* (Milan, 1987), p. 19 ss.

[24] Without entering into the validity of the points raised by A.N. WHITEHEAD, *Process and Reality* (Cambridge, 1929) and by C. Hartshorne, *The Divine Relativity* (New Haven, 1948), a legitimate use of this language can take place above all else within an "economic" context, that is to say the history of salvation as an exordial history of God. From this point of view, the Trintarian God suffers with us, but above all suffers in the Word made man.

[25] Cf. AGAIN S. SPINSANTI, *Salute..., op. cit*., p. 1138 ff.

CORRADO MANNI

Palliative Medicine and Christian Eschatology

In recent years palliative forms of treatment have rightly acquired a fundamental role in the sphere of social-health care. They have become the subject of great debate, and involve not only medical questions but ethical and social problems and dilemmas as well.

Furthermore, only very recently has palliative medicine begun to acquire the recognition of bearing the status of a new discipline of medicine—a discipline which merits the very greatest attention and should have devoted to it clear programs dedicated to its suitable development and diffusion.

First and foremost, I would like to refer briefly to the definition of "palliative treatments" which is offered by the World Health Organization: "palliative treatments consist of the overall care given to a person afflicted by illness who is no longer responsive to therapies which aim at a cure. Their aim is to obtain the highest level of quality of life possible for the patient and his relatives through the control of pain, other symptoms, and the psychological, social and spiritual difficulties which arise within the suffering group made up of the patient and those members of his family who share in his suffering."[1] The special characteristics of palliative treatments, therefore, are as follows:

1) they are used with incurably ill people;

2) as such, they are not primarily aimed at the achievement of a cure but seek to improve quality of life;

3) they are not directed towards the mere biophysical and pharmacological aspects of the illness but are conceived for the benefit of the suffering man, in all his physical, moral and spiritual aspects;[2]

4) they are not directed towards the individual patient alone but involve his family, both as an object of treatment and as an active force which takes part in the care and treatment of one of its members;

At the present time the number of patients who need palliative forms of treatment is constantly increasing, especially in the Western World.[3] This is caused by two primary factors:

The first is the increase in the incidence of pathologies which develop rapidly and lead to death such as cancer, AIDS, Alzheimer's disease, Kreuzfeld-Jacob's disease and various forms of multiple sclerosis. This phenomenon is partly linked to the increase in the average age of the population, which in turn is caused by improvements in health and social conditions and by a decrease in infant and youth mortality rates.

The second cause is to be found in the increase in the length of time that these patients go on living. This arises because of the greater effectiveness of medico-surgical symptomatic therapies and because of much earlier diagnoses of the patient's condition. There is no doubt, therefore, that although advances in medicine on the one hand have involved a drastic reduction in death rates, on the other hand they have also contributed to an increase in the length of survival, and to the numbers of those surviving, of patients afflicted by illnesses which at the present time are still incurable.

We are therefore face to face with new kinds of ill people who need very intense forms of care and treatment in the widest possible sense. In other words, attention must be directed towards the whole spiritual and psychosomatic complex reality of an incurable patient.

Indeed, there is no doubt that the patient afflicted by an illness which leads to death presents special difficulties and problems which a mere "technical" approach—directed, that is, towards the clinical aspects alone of the illness—cannot really solve.

Above all else, physical pain and the other disturbances linked to the pathology of which he is the carrier take on an especially serious character. This is because they do not go away but actually increase in intensity. Secondly, the direct effects of the illness—the mutilations caused by any surgical intervention which might take place and the general compromised condition of the patient—greatly reduce his independence and autonomy and force him to be dependent on other people.

Thirdly, the knowledge of the seriousness of his state of health and a diagnosis which offers no hope—which sooner or later grow in importance in the mind of the patient—present him with the anxiety of being deprived of his earthly life in the imminent future.

The combined pressure of these difficulties and problems cause deep spiritual and psychological concern and worry which give rise to the most desperate forms of reactions: incredulity, rebellion, disorientation, anxiety or depression. This further aggravates the physical suffering of the patient and worsens the course that the illness takes.

Unfortunately, in such conditions the relationship between the doctor and patient is not really suitable for a correct and sound management of such a complicated reality. Indeed, we can assert that over the last few years medical culture has become impoverished in relation to its "humanist" component and has evolved increasingly into a kind of "exact science"—something which is effective but impersonal and ever more distant from the transcendent nature of the great mystery of life, that very ele-

ment which always constitutes the purpose of its knowledge. The use of ever more sophisticated diagnostic and therapeutic procedures, an at times excessive employment of hospitalization, and the rationalization and formalizing of the approach to the patient—all these factors increasingly tend on the one hand to distance the patient himself from his own social and human environment, and on the other to create a gulf between the doctor and the sick person he is treating.

Of course, we do not want in any way to deny the evident benefits that technology has given to us. Nor do we wish to neglect the scientific rigor of our discipline. But we would do well to remember that technology has a value as long as it is used to the advantage of the patient. When, on the other hand, technology is employed merely for the benefit of science it ends up by promoting a "dehumanization of medicine," and this causes very great damage both to the patient and to the doctor who is looking after him. Another risk for the well-being of the delicate relationship between the doctor and the patient lies in the fragmentation of medical knowledge into a whole host of specialized disciplines which are principally directed towards the study of just one organ or internal apparatus—nephrology, pneumology, gastroenterology, cardiology or hepatology, to name just a few on the list. It cannot be doubted that the very considerable advances which have been achieved by modern science would not have been possible without moves towards a very high level of specialization on the part of those who have promoted such progress. But in actual fact many doctors have greatly altered their learning and ways of doing things with the result that there is a danger that they end up treaters of organs rather than of the body as a whole—something which should be their real task.

The increase in the number of disciplines implies a corresponding increase in the number of people practicing medical care. Indeed, it is not rare to come across patients in very serious conditions entrusted to the care of four or five different specialists, each of whom has the tendency to focus his attention on his own specific area of professional competence. And the presence of a doctor who oversees this diagnostic and therapeutic activity is often not sufficient to avoid losing sight of the whole patient and preventing the error known as "reductionism." It is precisely for this reason that we must always remember that it is our duty is to treat the sick person and not the illness.

The medicalization of the approach to the sick person is a major obstacle in the way of understanding his difficult human and spiritual experience (not to speak of the painful expression of the physical and moral suffering of his existence). But in the incurable patient other factors, in this instance of a social and moral nature, act to place other obstacles in his

path. Indeed, in an opulent and production-oriented society as is present in the West (where material prosperity is all too often held up as the only possible good to be aimed at and where the mass means of communication tend to construct an image of existence which consists only of beauty, wealth and success) the dark sides of life such as suffering, old age and death are ever more marginalized, almost as if there was an attempt to remove them altogether from the common consciousness. In a perspective which only includes worldly goods, the painful dimension to existence can only appear as an unthinkable and inexplicable void—something to be exorcised. Inevitably, the loss of a transcendental meaning to live deprives its natural conclusion—death itself—of meaning as well.

Behind the tendency to hospitalize the illness we often find an attempt to hide this painful dimension from the eyes of society. However the lack of acceptance of such a reality, its marginalization or the fact that it is concealed behind "technologism" and medicalization has a dual impact. On the one hand this reality is not prevented from being present. On the other, the ordinary person has become ever more unprepared to deal with it, the dying patient has had his suffering intensified and has to endure the moral and material consequences of an isolation of which all too often he is made the subject.

In each and every one of us the sight of the death of another person provokes discomfort because it reminds us of our own destiny. In the case of the medical doctor there is in addition a personal feeling of defeat in relation to his own abilities and capacities. The above mentioned reductionism also serves to promote this erroneous vision of things because it leads to a loss of the identity of the patient who becomes identified and confused with the disease he is suffering from. From this point of view death is wrongly seen as the final outcome of a pathology rather the natural end of a life.

We thus see how the above mentioned factors are closely interconnected: "technologism" and reductionism may at first sight be considered as mere "professional deformations" promoted by the medical class. In reality a closer and more accurate analysis shows how they are both the instrument and the justification of a more generalized cultural rejection of death which involves not only the medical doctor but society as a whole. This stance of rejection and detachment from incurable illness and its inevitable outcome can have two consequences which are only apparently in contradiction:

1) on the one hand, it can lead the medical doctor to persist, in obstinate fashion, with forms of treatment which have become useless and inappropriate and which cause further suffering without actually benefiting the patient. This error, as is well known, is designated "therapeutic obstinacy." Numerous factors give rise to this practice. Indeed, in addition to the doctor's inability to admit his inability to cure the sick person there is the fear that not "everything possible" has been done for the good of the patient, not to speak of an underestimation of the suffering which prolonged hospitalization and aggressive forms of treatment can cause to a sick person who is already under the full burden of a debilitating illness.

It is wise to make clear in order to avoid any possible uncertainty that by therapeutic overkill is meant the use of forms of treatment which are of proven uselessness in relation to

the overall goal. To this is added the presence of a high risk and/or a special danger for the patient, in addition to further suffering in a context where the exceptional character of the means and methods used is clearly disproportionate to the realities of the specific condition of the patient.[4]

The first criterion, therefore, is the proven ineffectiveness and thus uselessness of the treatment. This is based upon the evident contradiction to be found in the approach of the medical doctor—"overkill." By this is meant the obstinate and senseless use of a treatment which does the patient no good at all and which, indeed, cancels any "therapeutic" value. This, in turn, goes against the very nature of treatment which should in fact have the goal of improving the well-being of the patient and improving his quality of life.

Furthermore, it is more than obvious that, however involved, intricate, and complex a therapy may be, if it is suitable to the illness, it could never be defined as being an example of therapeutic overkill. The employment of advanced diagnostic and therapeutic resources which express a high level of technological expertise is fully justified only when the goal of such treatment is the well-being of the patient alone.

The second criterion lies in the intensity of the treatment—the extent, that is to say, of the risks it involves of causing new and additional physical and moral suffering. When such risks are high we can speak of a policy of "therapeutic violence."

The third criterion involves the exceptional nature of the therapeutic means and methods which are employed. These should never be disproportionate to the aims and objectives that the medical doctor has in mind.

It is evident that this last criterion is the subject of constant development within the world of medical science. Means and methods which at one time were considered disproportionate are today commonly and ordinarily employed. One need only think here of mechanical ventilation and of hemodialysis which are now practiced in the patient's home as well as in a hospital setting. Judgments as to the suitability of a treatment must be based upon a suitable knowledge of the clinical conditions of the sick person and on the practical benefits to be obtained from the therapeutic intervention. In the case of patients whose condition is very serious, where life expectancy is clearly low, such forms of treatment as pain killing, nutrition and hydration, dealing with bedsores, and helping with daily needs, do not, it must be observed, amount to therapeutic overkill—they are merely indispensable elements in maintaining the dignity of the life of the patient.

2) It should also be stressed that a doctor's knowledge that the patient entrusted to him has been diagnosed as being incurable can lead him to commit an equally serious mistake—to surrender, to turn his back not only

on useless forms of treatment but also on methods which would greatly reduce the suffering of the patient if employed in the right way. One is referring here, naturally enough, to palliative forms of treatment.

From this point of view the sick person who has no possibility of getting better comes to be considered a "lost" patient who is no longer worthy of real and authentic care, whether in a strict health sense or in terms of moral support. When the medical doctor who is in charge of the case has lost all hope of healing the patient, detachment takes the place of professional and scientific attention. In this way the patient is denied trust and spiritual support at precisely the moment when he has most need of such things. Information on the condition of his health become vague and evasive and in basic terms he is ignored. This is because the medical doctor is made to feel embarrassment at his lack of power to do something effective and experiences bitterness at his professional failure. Moved by pity, he may deal with the matter by giving a false picture of the situation to the patient.

In this way an error is committed which may be considered even more serious in its character and impact than therapeutic overkill—I am referring here to a real and authentic "therapeutic abandonment." This abandonment can lead to a complete dismissal of the patient because he is deemed incurable and no prospect of care is offered to him. To the moral isolation of the patient which is already present is added real and authentic material and social loneliness which afflicts both the sick person himself and his family. We need not add that this can but increase the number of serious difficulties which afflict both parties.

In reality the feeling of professional defeat provoked by the incurable patient—whose rejection is the basis of both the therapeutic overkill and the therapeutic abandonment—essentially derives from a misunderstanding of the real purpose of the doctor's mission which is seen solely in terms of achieving a healing of the patient. Once again care and concern for the sick person are forgotten and the illness alone is concentrated upon. In reality, whilst it is not always possible to achieve an end to the illness one can always and one should always offer care and concern. For example, diabetes is an incurable illness yet nobody would ever dream of defining it as being untreatable. What distinguishes it from conventional incurable illnesses such as cancer of AIDS is the different life expectancy of the patient. Yet the need for care and concern to be devoted to the patient is certainly not proportionate to the length of life which is still to be lived. Indeed, it is really the opposite which is the case.

In fundamental terms—and even when there is no longer any room left for the use of therapies which aim at destroying an illness (that is to say those which seek to strike at the cause of the malady)—it is the doctor's strict duty to do everything possible to remove the suffering connected to the illness itself, whether that suffering is of a physical or of a moral nature.

At this point it should be pointed out that clause 32 of the Italian code of medical ethics makes clear that "the doctor cannot abandon a sick person who is deemed incurable. He must continue to care for him even when a mere reduction of psychic and physical pain is envisaged, and he must help him and comfort him."[5]

In even more specific terms the National Committee for Bioethics during its press conference of 19 July

1994 to launch its publication "Bioethical Questions Relating to the End of Human Life"[6] stressed the very high bioethical value of palliative forms of treatment. These find their justification not in the false hope of being able to save a patient from death but in a firm determination *not to leave the patient alone*—to help him, therefore, to live out his last radical experience of life in the most human way possible, from both a physical and a spiritual point of view.

Principally directed towards reducing pain in general and the pain of terminally ill patients in particular, palliative forms of treatment have expanded and continue to expand their horizons and their sphere of action. They now constitute one of the fields in which modern medicine demonstrates its deeply rooted vocation to care for the patient in an overall sense, directing attention and concern not only towards the physical dimension of the sick person, but towards his psychological and existential aspects as well.

Furthermore, it should be stressed that care for the incurable patient acquires an even higher spiritual meaning in Christian ethics. For the Christian medical doctor, the first moral imperative is that of serving life, and this means looking after life until its natural end. Health care for the dying person is an especially important and delicate task because it involves making sure that the dying person sees himself and values himself as a living person. To quote the words of the Holy Father: "in nearness to death and in death itself it is necessary to celebrate and uphold life more than in any other context.... The approach to the terminally ill person is often the litmus test of a sense of justice and charity, nobility of the spirit, the responsibility and professional ability of health care workers, beginning with medical doctors"[7]. To help a person die means helping him to live out the last experience of life intensely. This is achieved through a loving presence at the side of the dying person. This presence makes him feel alive without giving him false hope. He feels a person amongst people because he receives, like any other person, but more than any other person, in this special context, care, concern and attention. This caring and careful presence must inspire trust and hope in the sick person and reconcile him with death.

It is evident that to be really able to inspire trust and hope the health care worker must be the first to make such values his own. He must not become a victim of discouragement or selfishness. He must know how to understand the transcendent and human dimension of the physical suffering of the sick person and the spiritual and psychological drama of the detachment which dying means and involves. These are by no means easy tasks.

We cannot deny that "when faced with the mystery of death we are powerless. Human certainties tremble. But it is precisely when faced with such a situation that Christian faith...presents itself as a spring of serenity and peace...What seemed without meaning acquires meaning and value."[8] In carrying out this task, the bearing witness to faith and to hope in Christ on the part of the health care worker acquires a determining role. "The demonstration of a presence of faith and hope on the part of a health care worker is the highest form of by which to humanize dying. It involves more than the alleviating of suffering. It means facilitating the sick person's drawing near to God through the employment of care and concern."[9,10]

At a practical level, therefore, the imperatives of the health care worker in relation to the incurable patient are as follows:

1) avoid a "medicalization" of the illness;

2) keep his treatment within the right limits of what is proportionate, with a consequent avoidance of therapeutic overkill or abandonment;

3) be a constant and caring source of hope and moral support for the patient and his family through a bearing of witness to the faith;

4) effect and promote by every means possible those forms of palliative treatment which reduce the suffering of the patient and thereby help to humanize death and make it more acceptable to the dying person.

This last consideration leads us to the need to emphasize that the employment of palliative forms of treatment involves programs which ensure the continuity of such treatment both inside and outside the hospital and guarantee a strong circle of care around the sick person. This cannot be achieved without a program which involves the relatives of the patient, the family's doctor, social and religious workers, and public structures.[11]

Unfortunately, this is still not very recognized at a political and social level. Today more than ever before social-health care has to deal with a lack of legislative and economic instruments at its command. We are constantly faced on the one hand with great success stories involving treatment in highly specialized centers. On the other, there are equally high-profile failings in the health services, even in relation to essential needs. The causes of these imbalances can only in part be attributed to medical doctors. They are first and foremost a reflection of a more general lack of interest on the part of society towards its weakest members—the elderly, the sick, and the poor. Many incurable patients in need of palliative forms of treatment belong to more than one of these categories—the elderly, for example, or AIDS sufferers, both of whom suffer from poverty and social marginalization, either prior to illness or (unfortunately) because of it.

From such a deformed point of view, the abandonment of the incurably sick person can appear to many as a necessary solution to reducing health costs and thereby helping patients who have a better prognosis. And this choice is often justified with the notion of "allowing the patient to die in peace at home" in order to save him the stress of hospitalization. In reality such a prospect is completely erroneous. The discharge of the incurable patient without providing for any program of palliative treatment or home support is not only ethically unacceptable but has very high social and economic costs which can be calculated in terms of the lost working days of the members of the patient's family.

This is caused not only by the need to look after the sick person but also by higher levels of physical and psychological illness caused by the stress of dealing with the illness and then with mourning. To this should be added the waste caused by an erroneous use of medicines, and above all pain killing medicines, because of a discontinuous or inadequate system of prescription.[12]

Even more worrying is the attitude of those who come to propose euthanasia as the only real solution when faced with the suffering of terminally ill people. This approach is justified with reference to the fact that in general it is the patient himself who asks for such an extreme solution.

In replying to those who propose such an extreme policy I do not propose here to dwell upon the intricate

set of arguments which go to make up the debate over euthanasia. I will limit myself to quoting the words of the Pope: "the pleas of very sick people, who at times ask for death, must not be understood as a real wish for euthanasia. They are in fact nearly always worried and concerned calls for help and affection."[13] The sick person who feels surrounded by a friendly presence and who perceives that his suffering is reduced does not fall into the depression experienced by those who feel abandoned to a destiny deprived of all hope."[9]

In conclusion I would like to observe that medicine today has many means available by which to control pain and confer upon the terminally-ill patient a dignified quality of life until that life comes to its natural end. There can be no excuses for ignorance or omission of their employment by health care workers whose very professional goal is the well-being of the patient. Palliative medicine makes euthanasia unacceptable and demonstrates that it is a policy which cannot be proposed. This is the strongest answer we can give to the "culture of death and abandonment."

Prof. CORRADO MANNI
Director of the Institute for Anesthesia and Intensive Care, The Catholic University of the Sacred Heart, Rome

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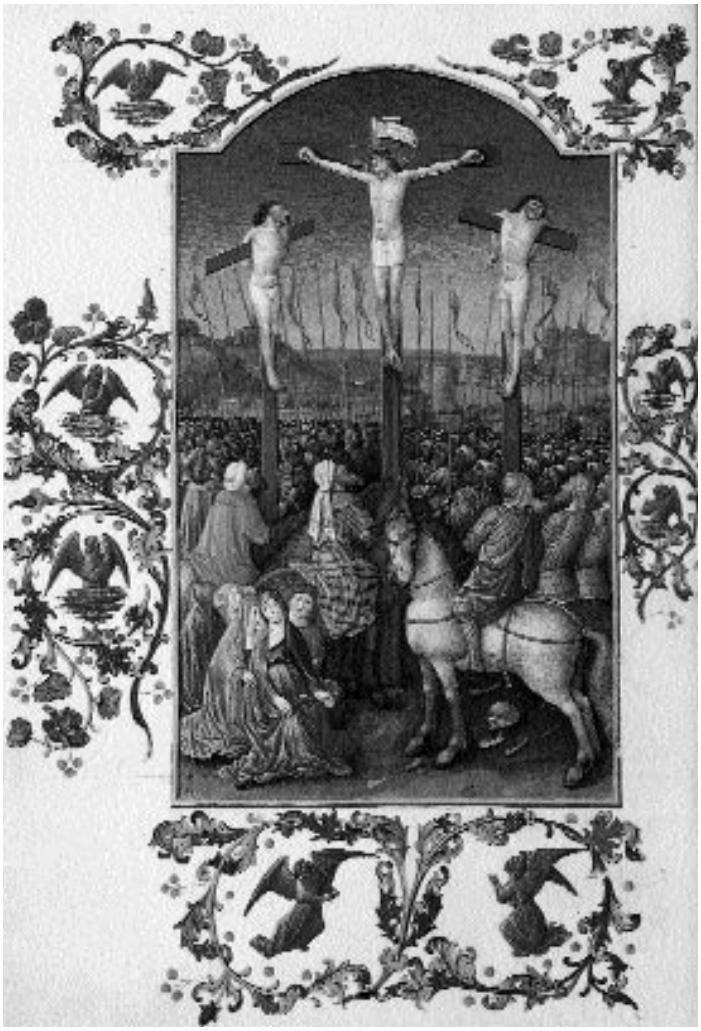

AN VERLINDE

Women in the History of Care for the Sick

1. Introduction

In all countries, in all societies, and in all epochs, it has been women, above all, who have taken care of children, women and men. Women have always been, and they are still, those who chiefly care for the sick, both at a professional level and in the private sphere—for example, home care and family care.

From an inquiry conducted in Holland in 1994—and it is reasonable to suppose that the results can be applied to the other industrialized countries of Europe — it appears that of every five hours dedicated to care outside the hospital world four are the work of women. Furthermore, over 60% of personal care is the work of wives, daughters, daughters-in-law and female relatives. In absolute terms were are talking about an important impact of the use of female work time.

One person in six of all people over the age of fifty-five receives care at hospital or at home. Furthermore, one in three women between the age of thirty and sixty are engaged in the provision of personal care. In short, therefore, the provision of care is the predominant responsibility of women. The results of an inquiry and a special investigation carried out for the fifteenth world congress of CICIAMS indicate that nursing and obstetrics are largely in the hands of women.

In industrialized countries about 85% of care for the sick and social assistance is carried out by women. Men entered the world of this kind of health care in the 1960s and since that date their proportionate role has remained more at less at the level of 15%. Statistics about the future suggest that this percentage will remain more at less stable over the next ten years. It should however be noted that of these 15%, about 60%, if not indeed 75%, have managerial and directive roles in the sphere of social assistance and this area of caring for the sick, and this development has been especially marked over the last fifteen years. Taking Michelle Perrot (1990) as a reference point I would even venture to talk about the "power of men and the force of women." In the history of men there are however a number of well known exceptions where women have ruled. Often these are dramatic exceptions involving women who have been heads of state or the commanders of armies, figures such as Catherine the Great or Joan of Arc. There have also been many examples of powerful and influential women who have played an important backstage and behind-the-scenes political role and have thus wielded great political influence.

We should not however be surprised at the fact that it is women who have largely engaged in professional and personal care for the sick. Many factors lie behind this reality, and the principal such factors are:

a) *The natural predisposition of women.* The natural disposition of women—that is,, to engage in such activity, a predisposition based upon the maternal care and concern of women which, in turn, comes to be extended naturally to all those who should be protected, comforted or helped.

b) *The role of women* within society. The sacred mission—that is, of devotion and altruism which come to be expressed in effective cooperation with the medical profession and in a technical science which needs excellent personal and manual abilities.

c) *The impact of history*. For many generations Western public opinion believed that care for the sick, devotion and self-sacrifice could only be achieved by belonging to a religious order and that this also required the taking of eternal vows and a permanent commitment to celibacy on the part of those women who wanted to dedicate themselves to care for the sick.

It is, however, a matter of fact that it has been first of all women in the West who have been given the task of caring for the sick, and it is also true that they have often been inspired by religious faith.

During the history of the Church, Christian women have always perceived, recognized and understood fundamental contemporary needs and have answered this call in practical fashion. In doing this they have always taken the gospels as their point of departure. They have done this with the total commitment of their persons and their lives and have used the specific instruments and methods of each epoch to achieve their ends.

Always inspired by the Holy Spirit, they have responded to the needs of their time, to the needs of the Church, and to the needs of the society in which they lived.

The Holy Spirit does not only illuminate the Almighty but also the deepest parts of man. It knows the needs of man and his most keenly felt wishes. And by illuminating the Word of God the Holy Spirit guides history. Man finds answers in the Word of God as well. What has marked Christian women is the fact that they have always come, and still come, towards man, as the example of Mother Theresa well demonstrates. They have also seen, and always see, man through the vision of God. In addition, they have been moved by the Holy Spirit and detect its presence in all men.

When Jesus had his feet washed

with spikenard ointment at Bethany he said: "You have the poor among you always." Down the centuries there have always been poor people and today there are more poor than ever before. Jesus Christ identified with all poor people on saying, "When you did it to one of the least of my brethren here, you did it to me" (Mt 25:40)

It is clear that a great many women have moved towards others taking the apostolic impulse as their point of departure. At the present time many male and female nurses and obstetricians who are members of CICIAMS perform their duties from an apostolic point of view and are thus to be placed in the tradition and historical trajectory of the Christian members of the nursing profession. This emerges from the answers of CICIAMS associations to the questionnaire published at the time of the fifteenth world congress of CICIAMS which was held at Louvain in Belgium in 1994.

Many people serve the mortal body of the Lord and this despite the fact that Mary had chosen the best part of all: "Martha, how many cares and troubles you have! But only one thing is necessary; and Mary has chosen for herself the best part of all, that which shall never be taken away from her" (Lk 10:41-42).

What does this mean? Should we think that Jesus rebuked Martha for her domesticity? How could he have criticized her for something? After all, she was completely taken up with caring for her Guest and offered hospitality to the Lord himself. Here were are not dealing with a rebuke because if such were the case nobody would care for those in need and everybody would choose "the best part" for themselves.

Nobody would give food to the hungry anymore; nobody would care for the sick; nobody would visit those in prison, and so forth. Our care and concern remain of the utmost importance and indeed are necessary to those who must be nourished. Martha and we ourselves, male and female nurses, and obstetricians, and all those who provide care, are dedicated to serving the mortal body of the Lord.

2. The Historical Evolution of Nursing

Every health care profession can be defined in relation to medicine. This is true of a branch which has achieved its own independence such as that represented by chemists, or of categories which have always been more or less independent such as nurses or the practitioners of kinesiotherapy.

Medicine and the whole of the professional health care world are defined within society in relation to the common interpretation of the origins of illness.

At one time—and this is often at times true today—the causes of each illness had a moral connotation. It was thought that illness was the result of a wrong which had been committed or of evil wished by others, both alive and dead. Thus it was that witches, seers and priests sought to identify the cause, to fight that cause, and to rehabilitate people who had been cured through the use of purifying rituals.

However despite this background medicine was able to develop instruments and methods which were often effective in their impact. The history of the nursing profession can be associated with the history of people entrusted by society with the provision of support and care for the sick.

A healer or practical man of medicine could at the same time engage in the medical diagnosis of the cause of the affliction, provide treatment, and act as a nurse, but such was not always the case. Indeed, in archaic societies where the division of responsibilities was not always clear the role of the physician often amounted to removing the evil which had been identified through the imposition of very painful practices which were made such in order to drive the evil—the unwanted guest so to speak out of the patient's body. The role of nurse was often performed by a woman of the family or of the tribe.

But we can trace the origins of the professional figure of the nurse, and thus a specific social group present within Western countries, to the rise of religious orders connected with the emergence of Christianity. Indeed, Christianity introduced revolutionary principles: human life is sacred, the poor and the sick are representatives of Christ and our love of God should lead us to come to their aid, without any distinction of race or religion. This, indeed, is the message of the parable of the Good Samaritan. The faithful gave their property and wealth to the Church and consecrated their lives to the practical implementation of these principles. Some lived in communities which gradually organized themselves under the authority of bishops. These communities had clear duties within society, and one of the most important of these duties was to care for the poor and the sick.

With the passing of the centuries the Church became a stable institution which enjoyed a recognized and organized authority and which could draw upon wealth and people consecrated to service within her ranks. In France, between the fifth and nineteenth centuries, the Church created numerous important institutions of various kinds to deal with the great failings of the social order. These institutions were refuges for pilgrims, orphans, the elderly, and beggars, and also performed the role of hospitals.

The administration of these institutions was usually entrusted to female orders, with the exception of the Hospitallers of St. John of Jerusalem, a male order founded in 1102 during the period of the crusades.

In addition to these kinds of institutions the Church also dedicated herself to direct and personal care for the poor and the sick. One of the most important creations in this area was the order of the Daughters of Charity which was founded by St. Vincent De Paul. The first school for nurses was established in Paris November 1633 by St. Vincent De Paul.

In the countries of the Reformation the religious orders were thrown out of the hospitals. In France their departure gradually took place between 1798 and the separation between Church and state in 1902.

But who took the place of these religious orders engaged in care for the sick? Down the centuries those of a religious vocation were helped by a staff which was illiterate and had not taken vows but merely worked in order to earn a living. Many observers of the time attested to the fact that the hospitals then went into a phase of decline.

In England another factor worked in favor of secularization. Industrialization favored the emergence of a middle class, led to the development of scientific medicine, and brought about the creation of the Red Cross.

The great protagonist of this change was Florence Nightingale.

This reform was based upon three main elements:
– the professional recruitment of nurses;
– formal training in schools which had an independent budget and a competent teaching staff;
– and work in institutions where the nurses were responsible for the organization and administration of nursing and cooperated with the management of the hospital and the doctors.

Florence Nightingale work ed in favor of the adoption of a professional approach on the part of nurses which was based upon a medical code of professional practice and upon Christian values. She herself used to say that "we must not only care for and heal the illness, we also have to care for and heal the sick person, and this on the basis of Christian values."

From the beginning of the twentieth century onwards three professional groups emerged in Europe and the industrialized world: those belonging to religious orders, those working in the public sector, and those working in the private sector. These three groups were very different. *The first* category was moved by personal commitment and entrance to it was based upon the taking of vows. *The second* sought a livelihood and entrance to it was achieved through a contract of work with an institution. *The third* category was animated by the wish to exercise a profession, which bestowed honor and prestige, prior to getting married.

These three groups also had certain aspects in common:
– There was no significant financial reward for the services rendered. This was because the female members of religious orders had taken the vow of poverty, the nurses in the public hospitals did work which was not very skilled, and the nurses in the private sector were engaged in voluntary work and disdained to receive a payment for what they did.
– Service was based upon religious, bureaucratic or military obedience.
– Little emphasis was placed upon professional training except in the case of service in the private sector.
– To sum up, therefore, it is possible to say that the dark period of caring for the sick finished when men and women inspired by religious sentiment became personally involved in this impoverished area of social assistance.
– I am thinking here of St. Vincent De Paul and his Daughters of Charity, of Pastor Fliedner and his wife, and of Florence Nightingale. It should be observed that Florence Nightingale herself received her training as a nurse from Fliedner and his wife and spent some time in the hospital established by St. Vincent De Paul in Paris.

3. The Modern Female Nurse: From Hippocrates to the Good Samaritan

The Hippocratic oath has determined the character of medical ethics for over twenty-five centuries. A new departure lies in the application of these general ethical principles to biomedical ethics. Another new element lies in the fact that ethical questions now require a interdisciplinary scientific approach. Medical doctors, members of the nursing profession, psychologists, the practitioners of kinesis, legal experts and others must reflect together upon the implications which technology now has for human dignity.

We all agree that biomedical ethics leads us to address ourselves to such controversial questions as abortion, AIDS, euthanasia, experimenting on embryos, and the transplanting of organs.

The members of the nursing profession are also led to think about the care that they provide every day. There is a distinction between the ethics of nurses and biomedical ethics first of all because the first are specifically concerned with professional activity in terms of the forms of care which are provided, and upon the role and the position of those who engage in such care. The present-day activity and actions of the members of the nursing profession, and the values and rules which govern such activity and actions, are the outcome of the tradition of centuries of institutional care.

We cannot forget the influence here of Florence Nightingale. We should however understand her in the historical context of the time and with reference to the condition of women during the nineteenth century. Before the appearance of Florence Nightingale the nursing profession simply did not exist. Care for the sick was considered the specific duty of the woman at home. It was thus an activity which was based on little formal training. It was not an activity which met with financial reward but was the fruit of maternal and devoted care.

The female nurse was not equipped with medical knowledge and always had to refer to the medical doctor, a paternal figure who dealt directly with the problems and difficulties of the hospital and the patients. It is therefore clear that the female nurse followed what the doctor said and obeyed his instructions much as occurred at the time in a patriarchal family.

Nightingale to a certain extent detached nursing from the family context because in her opinion nursing was a professional activity which should be based upon religious ideas and carried out by qualified nurses. For upper-class women this was an excellent opportunity to escape from the passive role of women which had been imposed upon them by society.

The religious beliefs of Florence Nightingale were expressed in her severe criticism of certain developments in the nursing profession such as the creation of professional associations for nurses, better financial rewards and improved social conditions of work.

In the opinion of Florence Nightingale such aspirations did not reflect the idea that the provision of care should be a religious vocation. Her ideas and approach, and in particular her religious convictions and her military discipline, have left a major mark on nearly all members of the modern Western nursing profession.

When she was asked what made for a good nurse she replied: "born in the church and raised in the army." This statement remained valid until after the Second World War. It was probably because of this that male and female nurses, obstetricians and social-medical assistants waited for a long time before establishing an international professional union. Under pressure from Belgian and French members of the nursing profession, CICIAMS was created only in 1936!

Florence Nightingale believed that the ideal nurse was a nurse who corresponded to the traditional figure of the "very upright and good lady" of the Victorian period. As a result emphasis was placed upon purity and upon devotion, obedience and loyalty towards the doctor. These values were expressed in the

"Florence Nightingale promise", the oldest statement of nursing ethics we have which is also very close in form and content to the Hippocratic Oath.

In the move from the nineteenth century to the twentieth century, and until the Second World War, numerous professional associations came into being for nurses and midwives. There was also a veritable explosion in textbooks and articles published by nurses and written specifically for nurses. It is important to notice that often great attention was paid to rules and regulations, and especially to those concerning the need for perfect obedience. There was also a specific set of norms of both a moral and civil character relating to decency and to how to behave—in a word, "ethics."

The articles published by Isabel Hampton Robb of the United States of America were an example of this and are commonly seen as the first step towards the construction of nursing ethics. At the same time a great many books and articles were published on the character formation of female nurses. The kinds of virtues which were invoked were: patience, love for one's neighbor, loyalty, purity, wisdom, honest, justice, and, above all, devotion.

Although medicine had undergone major development and advance for technological reasons, nursing remained loyal to these above-mentioned norms and conventions more or less until the 1960s. However, after examining these rules and regulations the lesson to be drawn is very clear—it was necessary to behave like the Good Samaritan.

After the 1960s great emphasis was laid upon the professional character of nursing and this involved the exact technical application of the knowledge and the methods which were available. In imitation of medicine, nursing had to correspond to the following ideal model. It involved the following elements.

1) A theoretical and systematic knowledge on the part of the nurse which would ensure the practical application of the directives of the profession;

2) A recognition by the patient of the authority and the experience of members of the nursing profession.

3) An ethical code to regulate the associations to which nurses belonged and to express the idea that a service is being rendered.

4) Access to the profession through monitored and regulated procedures of training.

5) Exercise of the profession by members of professional associations protected by law, and by these members alone.

6) The belief that professional associations have their own professional culture and formation which should be promoted by trade unions.

The process of the professionalization of nursing has involved a tendency to create a certain independence in the definition and exercise of what should be done—that is, autonomy and independence in the description and practice of the profession.

In recent times there has been an attempt not only to ensure an exact application of technical knowledge and methods but also to guarantee the application of the quality and the capacities of processes of communication. Furthermore, there is a keenly-felt need to devote mature thought to the activity and to the role and position of nursing staff.

We have witnessed the publication of a large number of studies about ethical questions and options, and a veritable explosion in the number of professional codes of conduct. In other words, it is reasonable to suppose that the members of the nursing profession want to express themselves more fully in relation to their role and on the subjects of a more "human" approach and the achievement of "good care". It should be observed that the parable of the Good Samaritan is often taken as a point of departure and as an example to be followed.

Conclusion

In conclusion I would like to quote the words of my predecessor, Miss Gh. Van Massenhove, the National President of the NVKVV and general secretary of CICIAMS. The difference between a profession and a vocation is to be found in the distance which exists between acting out of faith and charity and acting out of obligation and necessity. Between vocation and profession is to be found that enthusiasm which is expressed every day in caring for the less privileged and the most vulnerable.

AN VERLINDE
General Secretary of the Catholic International Committee for Nurses and Social/Health Workers (CICIAMS), Belgium
Consultor to the Pontifical Council for Pastoral Assistance to Health Care Workers

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BERNARDIN GANTIN

The Primacy of Life Under All Conditions, with Special Reference to Africa

In this paper I would like to:

1) talk to you first of all about Africa, a continent which, despite all the suffering it has to endure, continues to love life;

2) outline to you the moral, physical and psychological areas where life, unfortunately, is still wounded;

3) and describe what the Church is trying to do and the reasons we have for believing in the future.

1. Africa, a Land with a Great Yearning for Life

In one of the languages which is spoken in the south of my country (Bénin), man is termed "the father of life" and the fertility of God is termed "the mother of life." I believe that in many other African languages there must certainly be similar expressions which exalt and praise life and express its importance in the same way.

Indeed, Africa has a great hunger for life and strives to eat it to such an extent that in the eyes of many people this seems to involve a base pleasure. All those who have drawn near or have been in contact with this continent have grasped and understood that life and its promotion are at the center of all African concerns and on the horizons of its philosophy about things and its ideas about man.

The "Bantu Philosophy"—as indeed was once observed by Father Tempels in a way which had a great impact—well demonstrates how African realities are moved and animated by a kind of "vitalism"—that is, by the belief that life is of primary importance.

Subsequently, after Tempels, many works by African philosophers and young theologians have stressed how the trilogy of Life-Death-Life expresses the overall African interpretation of existence—an interpretation in which life itself occupies the primary position of importance.

It should also be observed that this attempt to make sure that death does not prevail partly explains the impulse to have a great many children. This practice aims at ensuring that notwithstanding everything, the high death rate will not destroy everybody.

This is borne out by the surprising peace of mind that Africans display when they are subject to great trial and difficulty. Indeed, they give the impression of playing, as it were, with death even when death never ceases to beat a path to their door.

It is without doubt this attachment to life, like the invention of a thousand methods by which to lessen the traumatizing effects of ill-fortune, which explains the survival of so many Africans who have been wrenched from their land down the centuries and have been taken far from their continent by methods of which we are all too well aware.

African native medicine, which we are still very far from knowing fully, has virtues which cannot be played down, despite the fact that modern science holds that its own therapeutic methods are best and goes on to impose these methods in order to ensure their success and diminish their failures. International organizations and associations should help us to explore this whole area in order to rationalize native African medicine and spread its use.

Despite the seduction of modern life and uncontrolled forms of urbanization which often take the form of a kind of free-for-all, Africa still retains, at least in essential respects, great respect for life and for elderly people. Indeed, elderly people are seen as the bearers of wisdom and their presence, although it is weak, ensures a certain balance within society and in particular in village life. Nobody wants to speed up the death of an elderly person or hasten the end of a person who is very ill because that person is no longer able to produce. However it is often difficult to find the means by which to take care of such elderly people.

This traditional African concern with the defense and promotion of life partly explains the population explosion which has taken place in the continent. There were 640 million inhabitants in 1994 and there will probably be 1,200 million in 2015—that is, 19% of the world population. It also explains the surprising youthfulness of the population. Indeed, without this new growth perhaps the continent would have met with a very serious fate. Africa survives thanks to its young people and it has the youngest population in the world (50% of Africans are less than sixteen years old). There is no attempt to stop life at its dusk, and in the same way there is no wish to strangle it after conception.

On the other hand there is no wish that such realities should blind us to the complicated and intricate character of conditions and realities in Africa and to the various hardships and trials which impede the advance and development of our continent.

We are reminded of the words of the Holy Father spoken during the special synod of the bishops of Africa which was held at the beginning of the tragedy of Rwanda, a tragedy which presented us with a whole host of questions and acted, so to speak, to obscure the face of African Christianity. Those words were as follows: "This continent loves life and cultivates death; believes in brotherhood but, alas, so often loves fratricide." It is our duty to analyze the causes of this paradox. It would certainly be useful for us to

ask and help the Africans to find the best and most lasting means by which to abolish the diseases and the tragedies which are placed in the way of the full development of the daily life of their continent.

2. Africa, A Continent Where Life is Fragile

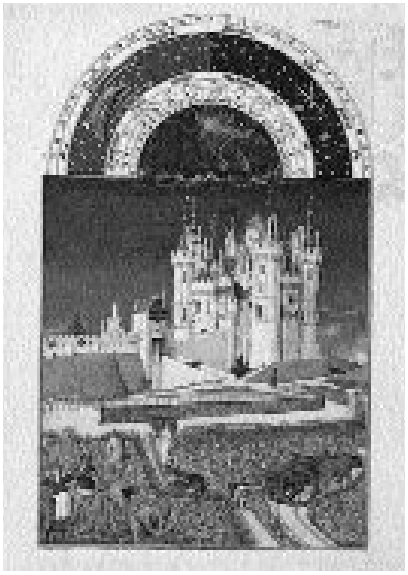
Health as everybody knows—although the point should be repeated—is a precious attribute for every individual and for society more generally. It is an essential element of well-being but as reports of the World Bank often stress: "there are also good economic reasons to justify expenditure on health services." This is because improvements in health levels contribute to economic growth and are an important factor in the fight against under-development. Questions and problems concerning health and health care, therefore, should receive major attention.

We are very happy and pleased that health standards have improved in the continent of Africa, as indeed they have around the world. But we cannot deny there are still many things which we have to do!

The difficulties of our economic systems have worked against the spread of the economic advantages which have been gained during these last fifty years. In particular, it is known that public hospitals and clinics—which represent most of the care and assistance offered by modern medicine—are often inefficient and the funds which they are given vary greatly from year to year. The recent appearance of the Ebola virus in Zaire and the deaths which followed that outbreak are a good example of this worrying state of affairs.

The poor are the first victims of these shortcomings in the public hospital system. The poor do not have access to basic health care and the treatment and help that they receive are very poor. But when we talk about the poor we are of course talking about the vast majority of the population of the continent. A great doctor who has dedicated forty years of his life to health care in an important African country has rightly referred to: "the great misery of hospitals in Africa." It is certainly true that much has already been done, may God be thanked. But there is still a great deal to be done in the way of increasing the quantity and quality of the medical and health care services which are available.

The situation of the continent of Africa in relation to the problems and difficulties of life thus impinges in painful fashion upon the conscience of Africa and calls upon Africans to deal with the whole question with greater determination. The various ills which torment the continent should be faced up to with greater lucidity and their causes should be analyzed with far-sighted responsibility. This situation also touches upon the conscience of the world which should express strong



solidarity and engage in a logic of shared international responsibility which does not stop but at mere palliatives but which works for something which is more long-lasting.

From this point of view it is deplorable that the industrialized countries do not hesitate to offload their toxic waste and other junk onto this already fragile and besieged continent. The international conscience should rebel against such behavior which endangers the very survival of many populations in Africa.

The African continent is the continent which is, unfortunately, most afflicted by death and by illness, those two great enemies of life.

2.1 Deterioration of the Health Care Systems

Let us consider first of all the case of the sick. Illness, we say in Africa, is the enemy of life. For fifty years basic health care and prevention through vaccination ensured substantial advances which contributed to demographic growth and gave rise to grounds for hope. Africa gained from the advances in health care throughout the world. Even though advances in health were at their lowest in Saharan Africa, average life-expectancy was raised from 39 to 52. But over the last ten years or so the return of poverty and abject poverty have caused the reappearance of such great endemic diseases as leprosy, malaria, tuberculosis, meningitis, typhus and dysentery. At the present time Africa has the highest rate of incidence of infectious diseases, and is much worse afflicted in this sense than Asia or Latin America. The reappearance of such diseases is to be explained with reference to the poor quality and ineffectiveness of our health care and economic policies.

To this long list of diseases we should add AIDS whose devastating effects cannot always be fully monitored. This plague is present in areas where there is great permissiveness or a high level of destabilizing conflict, factors which cause the migration of people and dangerous levels of promiscuity. Malnutrition has re-emerged on a grand scale. What we have to do is to be aware of the fact that delay in acting will greatly worsen the situation. As a result of all these factors the continent of Africa has the lowest rates of life expectancy and longevity on the whole of our planet.

2.2 High Mortality Rates and Their Causes

Africa seems therefore to be the land most afflicted by death in the world, and appears to be prey to a kind of trivialization and dehumanization of death itself. It is against these realities that we are seeking to mobilize all men of good will and in particular the governing elite of our continent. The trivialization of death, it cannot be doubted, is one of the causes of the general regression of Africa, a continent which is, however, full of natural riches.

What we have to do is to engage in a far-sighted analysis of the various historical, psychological, political, economic and religious causes of the wars which have devastated and devastate our continent, spread death, and severely impeded advances in the realm of health and health care, preventing thereby general and overall

progress. We have to engage in this analysis if we want to remove these causes.

From Liberia to the Sudan, and from Sierra Leone to Angola and Somalia, the number of our dead sisters and brothers killed in recent times cannot be counted. We can find no relief for our grief because we are dealing here with a real and authentic tragedy. We should pay especial attention to the cases of Rwanda and Burundi because their classic examples of fratricidal violence both cause us great pain and also constitute something which it is very difficult to explain. The fratricidal violence which has taken place in these areas which have a high concentration of Christians—has assumed very disturbing levels and leads us to reflection and to the examination of our Christian consciences, which naturally enough are very troubled by what has happened.

How is it possible that in Africa where there is so much talk about solidarity, ties of blood can prevail over ties created by the holy water of baptism? What we have to do is to ensure that the conscience of Africa demonstrates the limits which must exist in relation to the implications of ethnic loyalties, although this is not to deny that there are of course quite proper and legitimate feelings of ethnic identity. The life of a man cannot become of no consequence merely because he is a member of a different ethnic group. Nothing can justify genocide. Each man who dies as a result of the violence which exists in this continent is a loss for Africa and for mankind.

In this meeting of hope where we are examining the questions connected with life we can declare: "help us to overcome the forces of death; sell us more ploughs and agricultural machines and less arms, rifles and bombs." War is devastating the continent of Africa and needlessly leaving death in its wake. War is often caused by the irrational appetites of a few men crazed by a desire to conquer or keep power at any cost. But it is also often caused by the covert role of non-Africa powers which make war on each other by proxy, through the use of groups to found in Africa itself.

2.3 The Need to Respect the Human Person

The promotion and the protection of life in the continent involves the question of respect for the dignity of the human person and his rights—rights which are often violated on false pretexts: reasons of state, anarchic self-defense caused by the failure of legal authorities to provide suitable protection, torture by the police, the alarming increase in crime caused by abject poverty, unemployment and a wild process of urbanization which is causing a massive exodus from the countryside (at the rate of 3% of the population each year). This process of urbanization is even more disturbing and worrying given the fact that it is accompanied by a

relative absence of urban planning. This reality gives rise to whole host of problems and difficulties: a lack of health care structures, an increase in the number of shanty-towns, dangerously high levels of promiscuity, and insecurity and uncertainty of all kinds and forms.

It seems to us important to underline that the whole phenomenon of the city and city life should be re-examined in the light of the problems of development which afflict the countries of Africa. If we could solve these problems we could then go on to solve other difficulties. Diseases are often propagated by the cities precisely because they have become the pole of attraction for the movement of large numbers of people. At the same time, as has been observed above, the vast and sprawling cities which are becoming ever greater in number in Africa (as in other third world countries) do not have the financial and material means by which to provide effective health care and protection, and this is another major factor in the spread of disease in and from the urban areas.

What we have to do, therefore, is to start thinking about public health in the cities and this is because the great urban centers are major generators of infectious diseases.

Given the recent expansion of the cities, the success of preventive measures could have a rapid and positive influence on the rural areas where the inhabitants are in permanent contact with their city-dwelling relatives. The movements and behavior of these relatives often cause the transmission of disease to the countryside.

The Church cannot do everything, but she wants to make her own contribution to this important and valuable attempt to protect and promote the dignity of man. This endeavor is absolutely necessary and has a vital importance. We should not therefore be discouraged by the difficulties which we often find on our path.

3. The Christian Contribution, A Source of Hope

The Church gives great importance to this concern for human dignity because she believes in man, in every man, created in the image of God and saved by Christ, whatever his race, his origins or his human condition. This is a fundamental gift of the gospel message and a forceful expression of its spirit of universal love.

Together with education, which has always occupied a primary position in her pastoral work, health has always been one of the principal concerns of the missionary activity of the Church. From the moment when they took on this responsibility, the churches of Africa have sought to do everything to continue and adapt this apostolate in relation to the most disinherited populations of the cities and the countryside. Numerous wells have been dug within the framework of NGO programs and the initiatives of charity organizations in order to solve the problem of water. Hospitals, clinics, and maternity wards have been created in an attempt to improve health care.

Africans themselves have always been connected and associated with these initiatives and their practical realization, and this in order to ensure that they assume responsibility for the maintenance and upkeep of

these various amenities and structures. People only really protect that which they have built with their own hands. Africans should be helped even more in this overall endeavor.

How many human lives have been saved thanks to this charitable work of the Church which is part and parcel of her evangelical mission! This effort and this reality of financial aid should be continued and expanded, especially because government-provided services have become ever more ineffective or absent.

The various sects which are constantly increasing in number attribute great importance to the healing ministry of Christ. The established churches should realize how important they really are in the African context. In our continent the various populations have a great yearning for healing, for a healing of both the body and the spirit. We therefore should not lose sight of the fact that we are dealing with populations which are poor and fragile. We must be aware of the psychological dimension of things. After all, many evils have psychosomatic origins.

Education and the removal of ignorance are the right antidotes to the increase in illness and violence. Without giving the impression of wanting to take the place of the state in relation to ensuring health for all, the Christian institutions of the continent should fight on all fronts to protect the integrity of the human person.

It is in this overall perspective that the role of the Good Samaritan should be seen. The Church must follow his example and thereby give great credibility to her actions through taking to heart the defense of the life of men who are wounded by nature or by their neighbor.

Let us take advantage of this occasion to thank all those who have taken part in the efforts which have been made in Africa to improve matters. But we do not believe that the solution to the problems of Africa lies in easy answers which in reality could merely lead to new difficulties. It seems to us of the utmost importance that international organizations keep this fact very much in mind. Attempts to protect life must not take place at the expense of true morality. As Christians, we must stress this point to ensure that Africa, which from many points of view is a very fragile continent, does not end up by having to pay the bill.

Conclusion

Much has to be done in Africa to protect life and ensure that everybody and every individual has the best possible chances of survival. We know that the means we have available are limited and that we should not divide our forces. Clear and open cooperation between the Christian churches on the one hand and the state on the other can help to ensure that resources and efforts are united in order to achieve a solidarity-inspired process of mutual help which will prove very effective.

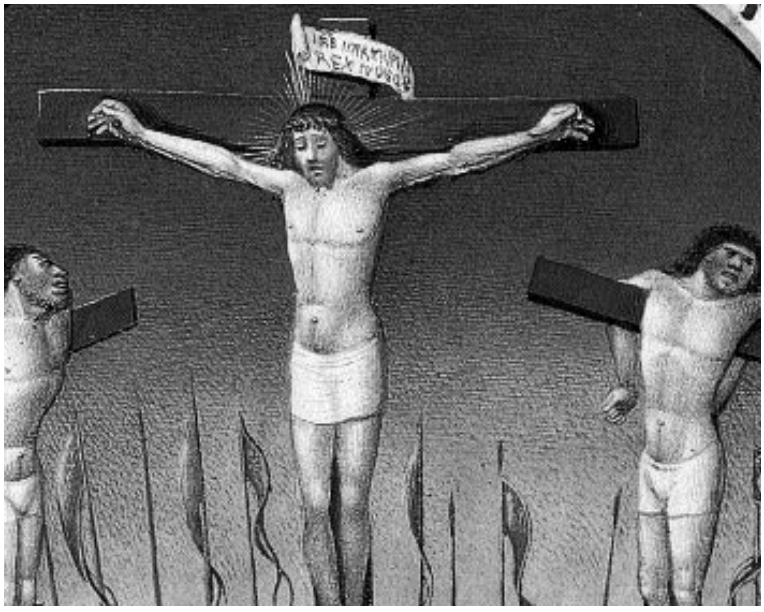
The international community can do a great deal in relation to the reform of health policy in Africa. It can help the Africans to deal with the problem themselves and thereby defeat the evils which afflict them. There seems an ever greater need for external support for research in the medical field which should be chiefly concerned with the great health and health care problems of the continent.

At the same time we should do all we can to eliminate the various glowing embers of war, many of which seem to be artificially kept burning.

The Christians of Africa do want to be and cannot be absent from such endeavors. The encouraging increase in the number of African Christians and the astounding dynamism of their churches are factors which push in this direction. The Christians of Africa must be the sun and the light of this land, a land which was the first to offer hospitality to the child Jesus, the Emmanuel, threatened by violence.

It is our most heartfelt wish that the continent of Africa will once again become the land of respect for life, and in very real terms the land of welcome and of peace.

BERNARDIN Cardinal GANTIN
Prefect of the Congregation for Bishops
The Holy See



YAW-TANG SHIH

Health Care and Quality of Life: Taiwan's Experience

I am honored to be given this opportunity to present to you Taiwan's efforts in the past decades in promoting respect for human lives through various health care programs.

Taiwan has made tremendous progress in improving the health of its people in the last 50 years. Life expectancy, for instance, has been prolonged from 53 years in 1951 to 72 years in 1993 for men; and from 56 years to 78 years for women in the same period. This progress has been made possible through various well-organized health care programs along with rapid socioeconomic development.

Taiwan's health care programs are organized around the following belief and principles:

– that human life above all is to be respected and valued;

– that health is a basic human right;

– that each human being is entitled to living in good health and in dignity;

– that access to adequate health care with equality and equity regardless of sex, age, and socioeconomic status is essential; in particular, the lack of financial resources should in no way be a reason for denial of adequate health care;

– and that, less privileged individuals of the society should be given priority care.

Around these beliefs and principles, Taiwan's health care programs have been organized, in the early days, focusing more on the protection of lives through programs to eradicate and control communicable diseases, such as the successful eradication of malaria in 1965, and through establishing more medical care institutions, government-operated health stations for instance, particularly at the grass-roots level in remote areas with fewer medical care resources, to care for the ill and to prevent the transmission of diseases. This focus has, in the last 15 years, been shifted to health promotion and health maintenance, that is, to remain healthy and be healthier, through education, preventive health services, development of positive health behavior, and, above all, by making health care available and accessible to all through the implementation of a national health insurance program since March 1, 1995, with a view to attaining the goal of health for all and to improving further the quality of life.

To cure the illness of an individual and thus to protect life, although it is an important task of the health care professionals, is only secondary. What is primary is not merely to preserve life but to improve and promote the health conditions of individuals, communities, and human beings as a whole, to allow peoples of the world to have a higher quality of life. After all, health is defined by the World Health Organization as: "not merely the absence of illness, but a state of physical, social, and mental well-beings."

Quality of life is a rather vague concept. From the point of view of health care, however, I believe it can be measured in terms of: 1) freedom from the fear of being infected with communicable diseases; 2) lower mortality rates of all kinds; 3) longer life expectancy; and 4) easy access to adequate health care.

By these criteria, Taiwan is a relatively healthy place, of relatively high quality of life. Almost all communicable diseases have either been completely eradicated or brought under effective control. Malaria, which at one time was a threat to the lives of many, was officially declared eradicated by the World Health Organization in 1965. Taiwan has been fortunate in having contained the dreadful AIDS epidemic to only 900 HIV positive thus far for a population of 21 million. The infant mortality rate has dropped to a low of 5 per 1,000 live births; maternal mortality to only 9 per 100,000 live births, or only 27 deaths in 1994. However, deaths due to accidents and injuries, particularly among young people in traffic accidents, are becoming a major concern. Life expectancy is now 72 years for men and 78 years for women and is expected to advance further. The newly implemented National Health Insurance Program, though only in its 9th month, has 96 percent coverage of the total population. Adequate health care is now available and accessible to each of the 21 million people.

Yet, we are not content. We are determined to see to it that every person on Taiwan, the Republic of China, will live longer, in good health and in dignity. To this end, Taiwan has launched several ambitious projects as presented in the Health White Paper, a copy of which is enclosed herewith, to further improve the health of the people and the quality of life.

1. Insurance Program, Attaining the Goal of Health for All

Health is a basic human right. For health promotion and mainte-

nance, easy and equal access to adequate health care is essential. Before the inception of the National Health Insurance Program on March 1, 1995, there had already been in Taiwan several government-operated health insurance programs for the laborers, government employees, and farmers, covering around 60% of the total population. The other 40% of the population not insured were primarily dependents such as the elderly and young children, who in general were more vulnerable to illness and hence would require more health care.

The main objectives of the National Health Insurance Program are: 1) to provide each citizen of the country with adequate health care; 2) to effectively utilize the available health care resources; 3) to reduce financial barriers to access to health care; and 4) to promote the health of the population. With the implementation of the National Health Insurance Program, this vulnerable group of people, who otherwise would have been denied access to health care, are now properly covered in this state-operated mandatory health insurance program. Further, in regard to human life, specific provisions are made in the National Health Insurance Program to care for the elderly and individuals of the less privileged groups, such as the handicapped, the mentally disordered, and the indigent. These provisions include: waiving of copayments for the continuing care of chronic diseases, for care of serious illnesses, for the indigent and for residents of mountain areas and offshore islands with fewer medical care resources; subsidies on premiums to the low-income families; reimbursement for home care services; and free physical examinations for the elderly. With the implementation of the National Health Insurance Program, the population as a whole and the less privileged individuals of the population in particular are now well attended to medically.

2. Development of Special Health Care Services

In addition to general health care programs, special programs have also been promoted to attend to the special needs of individuals of some specific groups, the elderly, the mentally disordered, and people in the remote areas for instance, with a view to reducing the differences in health care between groups and between urban and rural areas. Some of these programs are illustrated as follows:

a) Hospice Care

One is entitled to live in dignity; he or she is equally entitled to die in dignity. Medical care comes in both positive care and hospice care. For instance, one-third of cancer patients would require positive care;

the other two-thirds are beyond any remedy. To allow them to share with others the last moment of their lives in peace and dignity and without fear of death, plans have been formulated to develop in Taiwan hospice care on a pilot basis in some hospitals. Currently, there are 18 beds in the McKay Memorial Hospital, 20 beds in the Cardinal Ticn Hospital and 17 beds in the National Taiwan University Hospital. Physical, emotional, and social care and religious consultation for patients at a terminal stage and to members of the family as well are offered.

b) Emergency Care

With the rapid increase in motor vehicles, including motorcycles, accidents and adverse effects, particularly traffic accidents and accidents due to occupational hazards, have been the third leading cause of death in Taiwan for many years. Each year, around 13,000 persons die of this cause, most of them, regretfully, are young adults. Economic loss, particularly the tragic loss of young lives due to accidents, is beyond calculation. By age groups, motor vehicle traffic accidents and injuries are the first leading cause of all accidental deaths for all age groups above one year of age; drowning is the second leading cause of all accidental deaths for age group 1 to 24 years; accidental fallings are the second leading cause of all accidental deaths for age groups 45 years and above. Though safety education is most important in the prevention of accidents, adequate emergency care immediately after accidents is as important. To save lives and to reduce disabilities, an emergency care network has been established in Taiwan.

Local health authorities have been instructed to work in collaboration with police and fire departments to plan for regional emergency care programs, to set up an emergency care liaison center and a radio communication system to expedite emergency care. With the recent legislation of the Emergency Care Act, a mass training program will begin soon to train, in addition to medical personnel, fire rescue members and ambulance workers for them to provide first aid care to the victims on the spot and in the ambulance before they reach the hospitals.

c) Psychiatric Care

To respect the rights of psychiatric patients and to provide adequate care to them, the current policy in the prevention and treatment of mental illnesses in Taiwan is to promote positive care and rehabilitation and to reduce negative confinement and segregation. Taiwan is divided into several regions to form a comprehensive regional mental health service network. Patients are encouraged to receive adequate treatment, including treatment, and follow-up at both out-patient and day care clinics, and rehabilitation therapy in the community with a view to prepare them to eventually rejoin the community. In December 1990, a Mental Health Law was promulgated.

d) Long-Term Care

With the aging of the population,

around 7.1%, or 1.5 million, of the total 21 million population of Taiwan are above the age of 65 years at present, and the increase in chronic and degenerative diseases, the need for long-term care has become more imperative.

The elderly have been traditionally cared for, medically and in their daily life, by members of their families and/or relatives. With the changes in family structure, as revealed by a national survey in 1988, 14% (from 12% in 1986) of the elderly in Taiwan lived alone, 15% (14% in 1986) of them lived with spouses, and 68% of them lived with children; it seems that a more organized form of care for the elderly, if not to replace, at least to supplement the loosely organized traditional way of care, is called for. Currently, the long-term care of the elderly take the forms of home care (65 institutions providing this service), day care (around 240 beds), and care in nursing homes (11 insitutions with 450 beds for 24-hour service). The number of institutions providing long-term care is not sufficient; more will be done in the future.

c) Health Care in Remote Areas

The mountain areas and the offshore islands, where transportation and living conditions are often inadequate, are deficient in health care resources. To protect the health of residents of these areas, action has been taken: to train on government scholarships young students from these areas in medical and nursing education; to improve health care facilities; to promote telecommunication medical care; and to encourage private sectors through subsidies to establish medical care institutions in these areas. Provision is also made in the National Health Insurance Program to waive the co-payment of the medical care fees for residents of these areas.

3. Reducing Risk Factors to Health

In the ancient days in China and elsewhere in the world, people would have been overjoyed by the cure of a patient. Some decades ago however, people became unsatisfied with the cure of one patient alone; they began to explore the feasibility of preventing diseases in advance; several vaccines were then been developed as a consequence. Today, although disease prevention is still considered important by many, a new concept of positive health promotion has evolved. The mere absence of disease alone no longer satisfies people. People now look forward to living longer and in good health.

Poor health is very much behavior-oriented. Factors that may affect the health of an individual are: 1) biological factors, 2) environmental factors, 3) health care service and facilities, and 4) health behaviors and lifestyles. Among them, the health behaviors and lifestyles of an individual are the most important. The causal relation between smoking and health has been well established. Drunken driving is always a major cause of traffic accidents. Yet, in a survey of 1988, it was found that around one-third of the elderly in Taiwan smoked, one-fifth of them drank, 40% of them did not exercise regularly, 32% of them took high salt foods, and 27% of them took high cholesterol foods. Only some changes in these lifestyles and some control over these risk factors could bring about considerably better health conditions to the elderly in Taiwan.

To reduce, if not to remove entirely, risk factors hawardous to health, such as smoking, drinking, poor diet, lack of adequate exercise and, in the case of Taiwan, betelnut chewing, and at the same time, to develop positive health behavior are keys to good health. In this regard, several projects are ongoing;

For *health promotion:* anti-smoking, promotion of health fitness, nutrition and balanced diet, mental health;

For *health maintenance:* prevention of accidents and injuries, vision promotion, oral health; and

For *preventive health* services: maternal and child health, genetic

health, prevention and control of chronic diseases and cancers, long-term care, and primary health care.

Take anti-smoking, for instance; Taiwan initiated an anti-smoking program in 1987, when domestic markets were made open to foreign cigarettes. A survey in 1992 showed that the smoking rate for men above the age of 16 years was 55.3%, and for women, 3.2%. To fight against the hazards of tobacco to health, a Tobacco Hazards Act was drafted: to restrict or ban the advertisement and sales promotion of cigarettes, to place a warning label on each pack of cigarettes, to indicate nicotine and tar contents, to restrict smoking areas, and to prohibit selling cigarettes to minors.

The Act is currently being reviewed by the legislature. Meanwhile, intensive educational activities are going on to educate the public, and the school children who have not yet started smoking in particular, against the hazards of tobacco. In a survey, smoke cessation attributable to the effect of the anti-smoking campaign was estimated to increase from 1.6% in 1990 to 9.8% in 1992.

4. Conclusion

Taiwan is moving fast toward modernization and industrialization, and health is locked into the process, resulting in a decline in the overall death rate, which, however, can be expected to cease its decline and even to go up as the proportion of the elderly in the population continues to grow. Infant mortality rates may level off as the full weight of modernization is brought to bear on the health of mothers and children. However, there is little doubt that there still is substantial potential for further improvement to reduce differences from one area to another. This can be achieved if we as a society view:

1) the likehood that increased or sustained investments in basic biomedical research will yield new or improved technologies for the control of the major health problems;

2) the effects of alternative investment strategies focusing on the determinants of health;

3) the social, economic, ethical, and political costs and benefits of the first two points in various combinations;

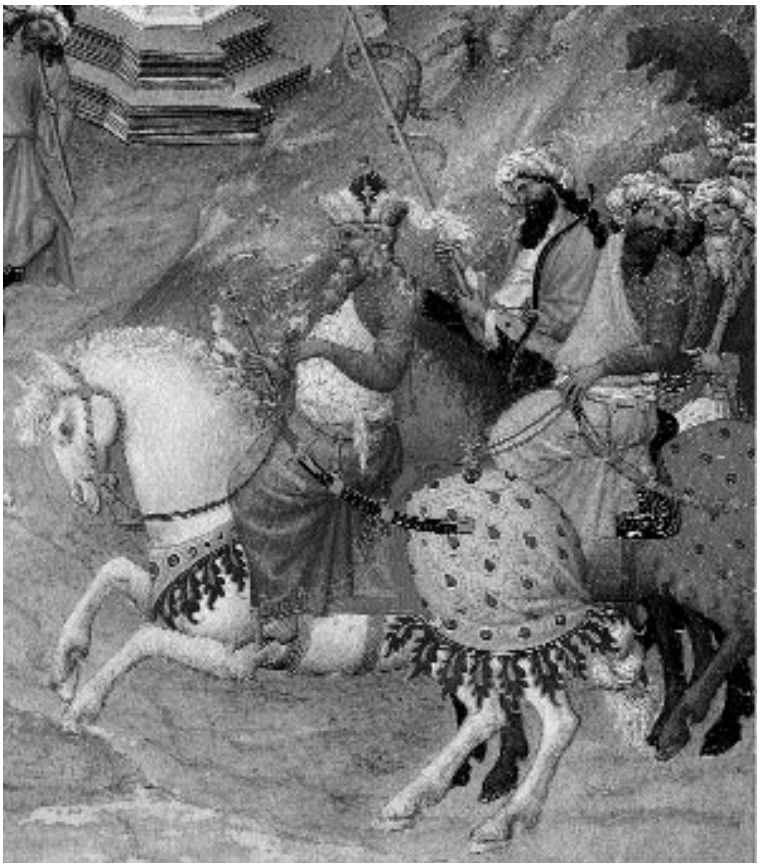
4) other social needs competing for available resources; and

5) our social and ethical concerns, both short and long-term, about the availability of life-saving, life-prolonging, and life-enhancing services.

We are unlikely to achieve these goals at one time. Resources are, as always, limited. Yet, we believe that while we are developing our economy, we shall also strive to reach the goal of health for all, and the eventual goal of a happy and prosperous society.

Dr. YAW-TANG SHIH,
M.D., D.R.P.H.

Deputy Director-General
Department of Health,
Yuan Executive
Taiwan



GEORGE ALLEYNE

The Primacy of Life

The very words included in this title give a sense of issues of really great importance and anyone attempting to do it justice must first explore the various interpretation that are buried in the manner in which it is phrased. My treatment of it must of necessity also be the result of my own disciplinary orientation in the social sciences—particularly medicine or rather health and—my responsibilities as Director of the Pan American Health Organization.

One possible interpretation is that in every corner of this earth there should be concern with the primacy of life under all human conditions—a position that seems almost trite. I must also avoid the tautology that is implicit in the interpretation that all human conditions imply everywhere on earth. I will address the topic as almost an affirmation that life of human kind is of prime concern and must take pride of place in our consideration of those matters that impinge on or determine the human condition. This concern for the human condition has to be at the center of all legitimate social endeavor and is the focus of all those like myself who practice the social disciplines.

I cannot enter the lists with the eminent philosophers who over the ages have debated and agonized over the meaning of life, or with the various groups of biologists who argue about the origins of human life, as we know it, or even with those who would question the existence of life forms outside the earth. I stress that it is human life that concerns us.

The preservation of life has been accepted as one of the fundamental rights. The liberalism advocated by John Locke argued that all human beings are equal and independent and *"no one ought to harm another in this life."* The liberal state of Locke's thinking sought to protect those rights seen as basic and all those who followed in this tradition such as Paine and Jefferson, reaffirmed the "self-evident" nature of the right of man to life, property, and liberty. Life was seen as a right or entitlement that must be ensured and should not be infringed upon by anyone.

The ultimate negation or deprivation of this right is death, which in its most violent forms is a brutal manifestation of the abrogation of the right to life. Human beings over the years have naturally been concerned that this right be protected and this anxiety is shown clearly in the Encyclical *Evangelium Vitae* (The Gospel of Life), in which His Holiness Pope John Paul II calls attention to

> *the extraordinary increase and gravity of threats to the life of individuals and peoples, especially where life is weak and defenseless.*

He is equally compelling when he says

> *- How can we fail to consider the violence against life done to millions of human beings, especially children, who are forced into poverty; malnutrition and hunger because of an unjust distribution of resources among peoples and social classes?*
> *- What of the violence inherent not only in wars as such, but in the scandalous arms trade, which spawns the many armed conflicts which stain our world with blood?*
> *- What of the spreading of death caused by reckless tampering with the world's ecological balance, by the criminal spread of drugs or by the promotion of certain kinds of sexual activity, which besides being morally unacceptable, also involve grave risks to life?*

Our many judicial systems go to great lengths to protect this right to life and punish those who, when they take it, deprive another of that which no person can replace.

Pope John Paul II goes on to decry

> *the emergence of a culture which denies solidarity and in many cases takes the form of a veritable culture of death—a conspiracy against life.*

It may be difficult to establish some hierarchy or primacy among basic rights, but I would venture that life indeed merits a very high position is any such hierarchy, if not indeed the highest place. The primacy of life among the other rights might rest on its non renewability in comparison with other rights.

Property can be restored and the individual once compensated may be almost whole again. Liberty, or the struggle for liberty, has been the battle cry of famous movements that through the years have changed nations. Although individuals cannot be adequately compensated for the period for which liberty is lost, yet liberty can be restored. The primacy of life might rest on the fact that the deprivation of it is absolutely and irrevocably finite. Life as we know it can never be restored and it is obvious that the person deprived of life can never be compensated for the loss of it. Nothing that the poets have written about the gloriousness of the manner of leaving life or the possible fruits of that loss can alter the stark immutability of the change.

The sharpness of the definition of the deprivation of life in death is ever present in the mind of the

physician, whose pristine function is to preserve life and avert death. The standards of ethical and moral behavior that are explicit in the Hippocratic oath enjoin physicians to do no harm, and in spite of the growth of the respect for autonomy, the traditional bedrock of medical ethical practice has been to make respect for life operational.

The physician of today often becomes embroiled in the intensive discussions about the preservation of life at different stages of the life cycle, and it is not unusual for some to feel slightly affronted when the moral concerns for the protection of life are crossed with the economic considerations.

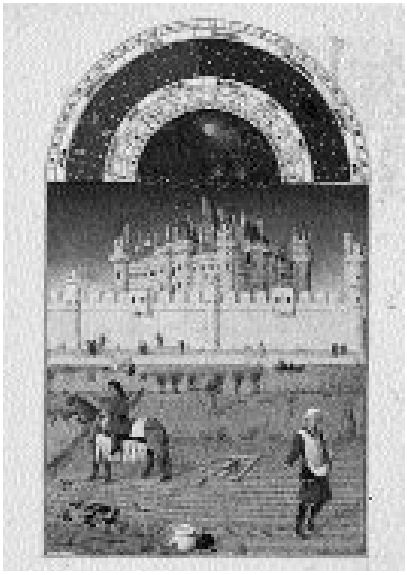
The value of life in economic terms has been a subject of continuing interest and sparked some of the political arithmetic that preceded the discipline of modern economics. But it is inevitable that we should think of the economic value of life and add these arguments to the moral ones for the preservation or amelioration of that life. To the extent that the wealth of a nation depends on production by its human resources, then life and the length of productive life will always be an economic concern. Much of the argument for improving or preserving life turns around possible productivity or loss thereof.

This debate about the absoluteness of preservation of life itself has economic ramifications and although a right implies that there should be a measure or protection, and I would add preservation, in the world of today this cannot be viewed only in the absolute. In spite of the affirmations about the primacy of life, because of the reality of limited resources, the view is often put forth and argued very vigorously that scarce resources should be applied where they should do best for the society as a whole. Thus we find government having to make decisions about the incorporation and use of technology which is known to prolong or preserve life but whose cost is prohibitive. The ethics of the allocation of resources of this nature go beyond the simple economic dicta that guide the application of such resources in times of scarcity.

The regard for the primacy of life and the perception that each life is precious and deserves special attention often leads to unnecessary ethical conflict between the deontological approach that gives primacy to the individual and the consequential dogma that focusses on the good of the many.

The sharpness of the divide is even more marked when resources are scarce and nothing has occurred to satisfy the modern Benthamites who do not often have to face the agonizing choice in the presence of individual human suffering and pain.

There are numerous biblical references to the importance and value of life and I always bear with me the



statement (John 15:13)

Greater love hath no man than this, that a man lay down his life for his friends.

This concept of life as the ultimate gift is in some ways more pleasing to me than the concept inherent in the Hegelian construct which portrays death or the loss of life as the ultimate chip in the serious struggle for recognition. Both views, however, are very compatible with assigning life a primacy beyond all human conditions.

But to most of us who work in health, there is another dimension which I will now explore. The primacy of life entails for us not only its preservation in an absolute sense, not only survival, but also some concern for the quality of that life. The right to life in some way implies the right to those states that make for a decent life, and high on the list of those states is health.

The best concept of the healthy life is one in which there is no disease in the pristine sense of the term. It implies one in which there is indeed mental, spiritual, and physical ease. It is not only the culture of death that must be counteracted, but it is the culture of quality of life that must be promoted.

Death is easily recognized and disease easily measured but the healthy state, for all its importance, is relatively invisible and it is sometimes this invisibility that leads to false perceptions. Health, like many of the other essential qualities that make humankind whole, is difficult to grasp and hold. It is when matters become visible, when the invisible state is lost, that we recognize the importance of what we no longer have. As I heard as a youth, "one never misses the water until the well runs dry." A part of our work is convincing our fellows that this invisible state called health is an essential resource for living, perhaps one of the only really and genuinely non-renewable resources. If we are going to engage others in the struggle to maintain that resource, we must clarify what its main determinants are. This approach is often bedeviled by the unfortunate fact that our best and most widely accepted measures of health are indeed measures of loss of health—measures of disease and illness.

In spite of the difficulties with appropriate measurement there is now general agreement on the determinants of that healthy state that indeed gives primacy and quality to life. It is important to understand these determinants, if individually or societally we are going to press for measures to preserve or restore health. The social and physical environments are dominant in this context. It has always been easy to grasp the impact of the physical environment on human health, and the appreciation of such an interaction reaches back to the writings and teachings of Hippocrates. It is true, however, that especially recently we have grown to understand this interaction somewhat better. The changes in the microenvironmental can easily be associated with disease and there is stark evidence all over the world of poor environmental conditions such as lack of water, poor waste disposal, contamination of the air and soil pro-

ducing disease, often of epidemic proportions. The lessons of John Snow, who showed us how cholera was related to fecal contamination of drinking water, have been repeated several times over. The tragedy is that, having learnt the lesson, we have been unable to apply the obvious remedy on a global scale. Cholera is still with us and children still die of diarrhea.

What is perhaps new is the appreciation that changes in the macroenvironment that have been induced by human action also lead to disease. The climatic changes induced by global warming and the changes in the protective ozone layer lead to both immediate and distant effects on health.

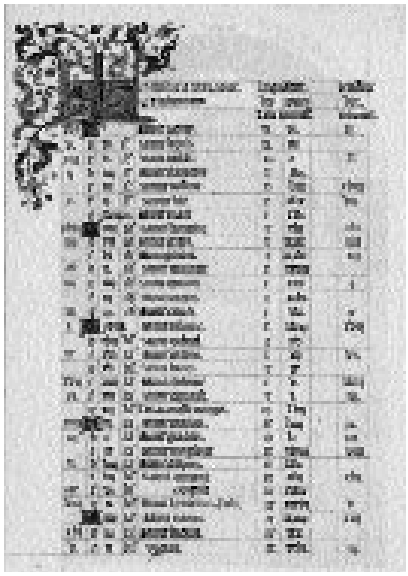
The impact of the social environment also has its history and the relationship of poverty to health was well recognized by Virchow in Germany, Villerme in France and Alison in Scotland. Chadwick and Shattuck are household names in public health because of what they did to ameliorate the social conditions and improve the health of populations. It is facile to say that poverty relates to disease and ill health solely through effects on the microenvironment and the possibility of nutritional deprivation.

But there is now a considerable body of literature relating health to social conditions, and the most striking findings relate not only to the influence of social class on health, but to the fact that this socially determined gradient in health is rather resistant to change. The famous Black report of 1988 analyzed the relationship between social class and health in Great Britain and showed that although health status improved absolutely over time, the gradient still persisted. The socially well off continue to have better health indicators than those at the bottom of the pile.

There is no doubt about this association, but the more fascinating research is directed towards elucidating its mechanism. The explanations are varied, but I have always been attracted to the thesis that the wealthy have access to more and better information and in addition are better able to internalize and utilize this information to create their own culture of health.

Individual and collective behavior are other determinants of health. There is evidence all around us of health damaging behavior that leads to disease. Smoking, unhealthy sexual practices, and eating habits are only a few examples of those bepatterns that impair health. One of the tragedies of our time is the insistence on autonomy and the right of self-determination to the detriment of both the individual as well as the collective good.

Genetic endowment is yet another determinant of our health, and until recently there was little that could be



done to alter this. It is often not the presence or absence of some genetic trait *per se* that leads to ill health, but because it predisposes to some other harm or injury. The ethics of genetic manipulation for correction of such defects are beyond the scope of this discussion.

In modern times, however, it is the care for the individual that consumes most of our attention. The injunction to care for one another and especially the admonition to the physician to care and cure are bedded deeply in our cultures and practices. Much of the expression of the primacy of life is through attention to individual care, and the sacerdotal origins of the healing profession speak to the importance of this care. The importance of care is clearly demonstrated in the attention paid to the care services and the institutions that deliver such care. The care system consumes by far the largest part of the budget allocated to health in any system. This is because of the origins of the healing profession, the public power of the most vocal of its members individually and in groups, and the normal anxiety of the individual that everything possible should be done to preserve life and avoid death. There is rarely any enthusiasm for prematurely "shuffling off this mortal coil."

However, when one examines the relative importance of these various determinants of health, it is clear that although the social and physical environments are the most important in promoting and maintaining the healthy state, most of the health resources go to the care services. No one would wish there to be such stringency that no or few resources are allocated to care, but concern for health as the expression of the primacy of life might be appropriately translated into having additional resources go to those other determinants that are shown to play such an important role.

Our concern for health goes beyond the individual and is also framed in the context of a wider good. The presence or absence of health or the uneven states of health in a society are often manifestations of inequity in that society. The reference by the Pope in Evangelium Vitae to poverty, malnutrition and hunger, as a result of an unjust distribution of resources among peoples and social classes, is a clear indication of the concern for the health manifestations of social inequity. Almost 20 years ago the nations of the world, in a remarkable show of unanimity and solidarity, raised the cry of Health for All. They did this with the full knowledge that there would never be some utopia in which there would be no ill health. They did it as a demonstration of the commitment to seek the kind of social equity that manifests itself in better Health for All. Like many noble and lofty aspirations, Health for All is impossible in the pragmatic programmatic sense.

Over the course of these last two decades there has been improvement, but there is a feeling abroad that much of the original enthusiasm has waned although there is still a great deal to be done. Our attention is being struck by pictures of large populations suffering and new dis-

eases emerging. Indeed, the concept of new, emerging and re-emerging infectious diseases in now high on the agenda of the world's public health. Human Immunodeficiency Virus Infection/Acquired Immunodeficiency Syndrome (HIV/AIDS) may be the best known example of a newly emerging disease. But poor sanitation, ecological changes, and rapid transportation are all contributing to new threats, and there is no doubt that their impact is and will be global. These diseases are problems of the developed and developing world alike, and the efforts to warn us of them and hopefully counter them will need a global effort.

Our countries are seeking to renew the call for Health for All, because they appreciate the timelessness of the goal. But now there is the added dimension that there is a more conceptual clarity about the role of health in relation to those other activities and attributes that combine together to make for human development as a state in which there is truly a flowering of the human spirit and the possibility for humans to achieve more of their potential.

I would hope to persuade you that at this time we need to see health not only in sectorial terms and as an issue of concern to the health professionals. Health touches all sectors, and one of the elements of this renewal of Health for All is to give more emphasis and meaning to the interaction of health and other aspects of social endeavor. We need to see health so located in the public agenda that all actors in society appreciate their roles in promoting the concept of health as a resource for our full being and something to be bemoaned for its absence.

Health is essential for living, but health is also a powerful force for securing conciliation and reconciliation. Our experience is that it represents one of the noble areas around which there is little conflict and for which it is relatively easy to secure the dialogue that can lead to understanding and peace.

Mr. Chairman, by training and conviction, we who work in and for health believe in the primacy in life, and see that primacy expressed most beautifully in the promotion and preservation of that most precious of resources—our health. But it would be a semi-tragedy if this vision remained only with those in health, and I would wish to see all human beings share it. Perhaps when that day comes, we will indeed see not only improvement of human conditions everywhere on earth, but there will truly be recognition that this primacy of the life that we hold so sacred will indeed be acknowledged to be important under all human conditions.

Sir GEORGE ALLEYNE
Regional Director for the Americas of the World Health Organization, Barbados Islands

I wish to acknowledge the help of Dr. J.R. Ferreira in preparing this manuscript.

FRANCIS ARINZE

The Pedagogy of Pain in Other Religions

1. A Phenomenon That Imposes Itself: Man and Pain

Pain is a reality which faces human beings during their earthly pilgrimage. It comes in many forms. Physical pain can come as bodily aches, physical hurts and wounds, weakness, hunger, sickness, old age, or death.

Mental, spiritual and moral pain can take the form of disappointment, failures, ingratitude, false accusation, insult, or marginalization. It can also be caused by the death of dear ones.

Unpleasant weather conditions, accidents, fires, and natural disaster also make people suffer. Pain concerns man in his entirety, in his sometic-spiritual unity.

Pain accompanies man and practically demands his attention. It imposes itself on man as a subject for reflection and meditation.

Man throughout history has asked questions about pain, about suffering, and about evil. He has sought their meaning and the answer to them.

The Second Vatican Council wisely notes that "men look to the various religions for answers to the profound mysteries of the human condition which, today even as in olden times, deeply stir the human heart" *(Nostra Aetate, 1)*.

Pain is one of those profound mysteries. How do Hinduism, Buddhism, Judaism, Islam, and African Traditional Religion offer to their followers an answer to this unavoidable enigma? What reflections can we make on these answers in the light of the Gospel of Our Lord and Savior Jesus Christ and the Christian faith?

2. Hinduism on Pain

a) The Law of Karma

Basic to an understanding of the Hindu approach to the mystery of pain or suffering is the Hindu belief of the law or theory of Karma. The word Karma means action, work or deed. Hindus believe that the immortal self (or soul) is the substratum of knowledge, action and enjoyment. Every action of the self, whether good or evil, produces a corresponding unseen result. This result is to be enjoyed or suffered by the doer in this life or in the life to come. The nature of the embodied existence in the next life (because Hindus believe in re-incarnation) is determined by the actions of this life and of previous lives. Therefore the body and the spatiotemporal circumstances which a person has here and now are not accidental. They are the sum total of all the results of all the Karmas of the previous births.

b) Pain is Merited

If, therefore, we ask why a righteous man undergoes sufferings and miseries and has to face problems in life, Hinduism answers that he has been an evildoer in his previous life or lives. One is born blind because he has sinned with his eyes in his past life or lives. Suffering, miseries, evils, and problems in life, in all their shades, are thus explained by means of the eternal *karmic* law.

c) Other Causes of Suffering

Particular interpretation or schools of hinduism suggest other causes of pain and suffering, such as the gods, or the material world, sorrow and ignorance, a fragmented vision of reality, egosim, hunger and thirst, old age and death.

d) Response to Pain

Hinduism teaches that the response to pain and suffering is to be found in virtues like renunciation, austerity, study of scriptures, non-violence, truth-force or *Satyagraha* (i.e. when filled with truth, a person has inexhaustible power to do good), help of a *guru*, etc. The three classical means or paths for liberation in Hinduism are the path of knowledge, the path of loe of God and the path of disinterested action.

e) God's Role

How does Hinduism see the role of God in human suffering? God is regarded as impartial. He allows people to assume bodies destined for them by their own past *Karmas.* But He gives them free will, and they can, by strenous practice of spiritual means, destroy all the results of *Karma,* and thus break the chain of births, deaths and rebirths, and obtain eternal liberation. In classical systems of spirituality like *Samkhya* and *Yoga,* God is not regarded as concerned with the salvation of man. The seeker wins liberation by his own efforts. But in the theistic *Vedanta* systems and in the *Bhakti* literature, God is coinceived as a person and His help is regarded as essential for the salvation of man.

f) Value of Pain and Suffering

On the whole, Hinduism sees no positive value in pain or in suffering. Suffering is regarded as a result of *Karma.* However, the holy people and mystic of the *Bhakti* movement willingly accepted sufferings to express their intense love of God. For Hinduism, there is positive value in self imposed suffering, such as

freely undertaken renunciations and the practice of rigorous ascetism. These are regarded as means to salvation.

3. Buddhism and Pain

a) Liberation from Pain and Suffering

Suffering is the point of departure and indeed the foundation of all Buddhist teaching. Buddhism can indeed be said to be a doctrine that preaches the liberation of humanity from suggering. The teaching of Buddha is summarized inf our Noble Truths, all with reference to suffering, regarding its truth, its cause, its end and how to be free from it and reach the *Nirvana.*

The first truth, the Truth on Suffering, says that everything is suffering: birth, sickness, old age, union with an unloved person, separation from a loved one, not getting what one wants; in short, the five material and spiritual elements together with attachment are suffering. Every happiness or joy in this world, marked as it is by instability and transience, is already suffering. Buddha says that during our existence we have shed more tears than the water contained in the four oceans (cf *Samyuttanikaya* II, 180).

Buddha says that the cause of suffering is attachment. This can take the form of longing or thirst for things, or an egoistical clinging to them. It can lead to the fear of loss. This is the second truth about suffering.

b) Nirvana

The third truth about suffering refers to its end or conclusion, the annihilation of attachment-thirst, of hatred and of error is *Nirvana*, the state of holiness. *Nirvana* (exit, escape) is the suppression of the fire of attachment-thirst and of the passions. Buddhist ascetism aims at reaching the nirvana (extinction) of self and the purification of self. The Buddhist saint is the one who has realized on emptying and denial of self and passions.

Nirvana can be reached in this world by destroying selfish attachment which is the root of all suggering, but it is obtained in a definitive way only after death. The Nirvana, because of the absolute absence of suffering in it, is called Ineffable Peace, Perfect Calm, Supreme Beatitude or Full Happiness.

In the fourth truth, Buddha indicates the way that leads to the Nirvana. The octuple Way to Righteousness is as follows: right vision, right thought, right word, right action, right life, right effort, right attention and right meditation.

c) A Moral and Soteriological Way

Buddhism responds with silence to all questions on God, man and the universe. Buddhism is not a meta-

physical system. It is solely occupied and preoccupied with the salvation of all beings from the evil that is suffering. Buddha did not deny the existence of metaphysical problems but he denied their usefulness. Buddhism is summarized in the saying: "Avoid evil, practise good, purify the heart, that is the teaching of Buddha" *(Dhammapada* 183, *Majjhimanikaya* II, 49). The octuple Way to Righteousness names eight virtues, all moral, and none refers to God.

4. Judaism and Pain

a) Punishment and Responsibility

The Bible is from the beginning aware of suggering as a characteristic of human existence (cf Gen 3:19; Job 5:7). The Jews had a strong sense of community. This included the expectation of collective punishment or suffering: "The fathers have eaten unripe grapes; the children's teeth are set on edge" (Jer 31:29; cf also Ezk 18:2). But soon Jeremiah (Jer 31:30), and more definitively Ezekiel (Ezk 18), asserted the principle of individual rather than collective retribution.

b) Explanations of Pain and Suffering

The book of Job and Ecclesiastes show how the Jewish mind was puzzled and disturbed by suffering, to which no answer was found. There appears to be no final solution to the problem of the suffering of the innocent person apart from faith. A person must see God, encounter God, and bow in adoration before God, if he is to live with pain and suffering.

In Alexandria, Egypt, the *Wisdom of Solomon*, a book which appeared about the year 90 B.C., stressed clearly a definite faith in future rewards after death, and the consequent reduction of attention on sufferings that exist at present. Retribution takes place for each individual after death. The Pharisees believed strongly in the resurrection of each person.

Maimonides believed that the particular evils which befall a person are for the good of the universe as a whole and that all suffering is punishment for previously committed sins.

Buber held that evil is really only a "turning away" from the good towards "nothingness."

Judaism in its nonphilosophic form acknowledges the utter reality of evil and suffering. Indeed, God Himself is often described as suffering with man. Man is challenged to remedy suffering whenever it can be remedied, and to endure it without complaining whenever it is irremediable.

Another explanation of the existence of suffering is that it is a process of purification. The Talmud terms such suffering "afflictions of love." Suffering was thought to be the ultimate form of divine purification leading to mystical union.

In the 20th century the terrible calamity of the Shoah (Holocaust) has brought up the question of suffering in its most acute form. How could so many innocent people undergo such terrible tortures and ig-

nominious death? Where was God in all this? Jews have been compelled to seek a meaning for this mystery of evil, often through one or more of the explanation given above. But at times they prefer just to remain silent before this mystery.

5. Islam and Pain

a) Suffering Will Be Redressed

The *Qur'ân* and Islam see the life of God's prophets as going through the stages of proclamation of the divine message, human opposition, persistance by the prophet in suffering and ultimately vindication by God. In times of suffering, the good Muslim does not despair of God's goodness nor become self-destructively bitter or destructively angry. He or she strives to wait patiently with full faith that God will eventually redress the wrong and make things right. The Qur'an denies the crucifixion of Christ and His death because that would have meant failure or that God abandoned Him.

b) Other Islamic Traditions

The Shi'ite segment of the house of Islam has a different tradition. It believes in the vicarious efficacy of suffering. For the Shi'ites, the Imams (especially Hussain, grandson of Muhammad) took upon themselves the sinfulness of humanity, and by their faithful patience in tribulation and persecution, they atoned for all the evil that humans do to one another.

Worthy of mention is a high-ranking Sunni mystic, al-Hallaj, who considered that the perfection of Islam (total abandonment to God) lies in "total abasement," that is, in "death on a gibbet." Indeed, he was crucified in Baghdad in 922.

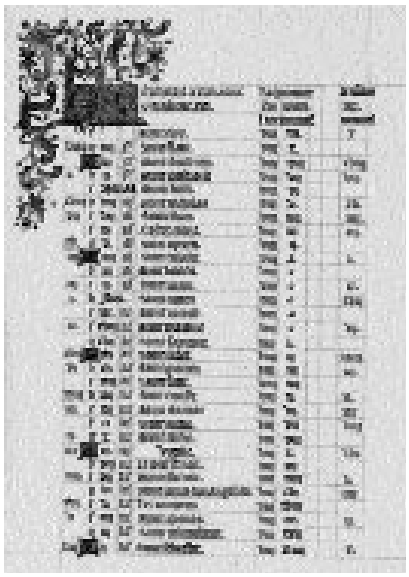
6. African Traditional Religion and Pain

a) Causes of Pain

The religion prevalent in most parts of Africa before the arrival of Christianity and Islam believes in God, in spirits and in the ancestors. Its followers see pain and suffering as having many possible causes. Moral faults—such as stealing, slavery, adultery, incest, abortion and murder, are believed to provoke punishment from the spirit and ancestors, in the form of sickness, epidemics, road accidents, drought, flood, childlessness and death (especially death by lightning). The breaking of taboos is also believed to provoke evil and punishment. Pain can also come, it is believed, from the caprices of evil spirits, blind forces and witchcraft. God is generally not regarded in this religion as responsible for any of the suffering which people undergo.

b) Attitude towards Suffering

To remove suffering, the devotees



of African Traditional Religion take some of the following measures: consultation of the fortune-teller to find out which spirit is angry with them, placatory sacrifices to the indicated spirit or ancestor, and resort to real medical doctors who are expert especially in herbal cures. There is also the belief in fatalism, in suffering which is neither merited nor preventable.

7. A Christian response

To conclude these reflections, it is now necessary to ask ourselves what comments can be made in the light of the Gospel of Our Lord and Savior Jesus Christ, on the answers proposed by these religions to the mystery of pain and suffering.

a) Salvific Value of Suffering

God loves humankind. Because of this great love, He sent His Only Son to save all men. "God loved the world so much that He sent His only Son, so that everyone who believes in Him may not be lost butmay have eternal life" (Jn 3:16).

Jesus Christ saved all humankind by His suffering, death and resurrection. He did this out of love for His Father and to save all men. Thus Jesus gives meaning to pain and suffering. And He invites all His disciples to take up their cross and follow Him. By mystical union with Christ through suffering, the Christian discovers the salvific value of suffering and is able to beat it with love.

b) In Response to the Various Religions

To Hinduism, the Christian faith proclaims that death is the end of man's earthly pilgrimage and that there is no reincarnation (cf. *Catechism of the Catholic Church*, no. 1013), but rather life after death in heaven (directly or through purgatory) or hell. While suffering can sometimes be the fault of the one who suffers, it need not always be so. Efforts at asceticism and detachment from creatures are praiseworthy, but Christianity teaches that we depend absolutely on God's initiative for our salvation. Without God's grace we cannot achieve perfection or salvation, although our cooperation is required.

While Christianity shows appreciation for the sincere efforts which Buddhists make at asceticism, there are major differences . Christianity proclaims the essential good of existence and the good of that which exists. Above all, Christianity proclaims the existence of a transcendent God Who is goodness itself and Who lovingly created human beings and wants their happiness. Man suffers on account of evil, which is a certain lack, limitation, or distortion of good. Man is not able to procure for himself eternal beatitude. He has an absolute need of the assistance of God's grace for this. For Christianity, salvation is the liberation of humanity from sin by the suffering, death and resurrection of Jesus Christ. The Passion of Christ is part of His Paschal Mystery; for Christians, suffering is not a negative factor from which man strives to liberate himself, but is a way to carry our cross and follow Christ, Who saved us by His Cross.

Jews and Christians share that revelation of God to humanity which is preserved in the Sacred Scriptures regarded by Christians as the Old Testament. Those Scriptures present the figure of the Suffering Servant of Yahweh. Christians see in these texts (Is.42:1-9; 49:1-6; 50,4-11; 52:13-53:12) a foreshadowing of Jesus Christ, Who suffered for us. "Ours were the sufferings He bore, ours the sorrows he carried..., and through His wounds we are healed" (Is 53:4-5). Jesus Christ is the full and final manifestation of God's glory and of His saving love for humankind. In Christ, suffering is given meaning. The Cross becomes a source of salvation, peace, and joy and a call to discipleship of Christ and to love of our fellow human beings who are suffering.

Towards Muslims, Christians show appreciation of the virtue of obedience to God and patient carrying out of His will, as well as the Shi'ite perception of the value of vicarious suffering. A major difference is that Christianity stresses that love is the richest source of the meaning of suffering,—that is, it was out of love for His Eternal Father and for all men that Jesus Christ suffered the ignominy of crucifixion and that the crucifixion was not defeat for Christ but His victory, because He rose again the third day. The glorious Resurrection of Christ is central to faith in His mysteries. Christ has thus given suffering a salvific value, and the Cross is a sign of His triumph. As followers of Christ, we do not abandon ourselves to fatalism when suffering comes our way, but rather we feel called to carry our cross and follow Christ, the Conqueror of sin and death. And we do not always expect that God will visibly manifest the victory of the person who is faithful to Him.

Followers of African Traditional Religion will be gladdened by the liberating influence of the religion established by Jesus Christ. The Gospel frees man from fear of blind and malevolent forces, and introduces him into the loving plan of a saving God Who sent His only Son to redeem humankind by His suffering and crucifixion. Christianity is an offer of God's love in Christ to all humanity. Man's response to this call includes willingness to undergo the suffering that comes one's way. Thus, one carries one's cross and follows Christ in loving union.

As can be seen, the Gospel is not a higher edition of other religions. It is a supernatural and totally novel irruption of God in human history. It is a call to a life of union with God to which man could never by his own unaided powers aspire. The Gospel gives meaning and a sense of direction to pain and suffering. It gives a completely new and otherwise unattainable dimension to human existence. Blessed be God!

FRANCIS Cardinal ARINZE
President of the Pontificial Council for Interreligious Dialogue, Holy See

ALBERT VANHOYE

The Good Samaritan (Lk 10:29-37) Biblical Hermeneutics of the Parable

The parable of the Good Samaritan—which is the point of departure for this tenth international conference—from the point of view of biblical exegesis raises a large number of questions and displays highly indicative characteristics. In this short paper not all of these aspects can be examined but I will at least strive to ensure that nothing essential is omitted from my talk and analysis.

The text is only to be found in the Gospel according to St. Luke (10:19-37). It is in harmony with the special emphasis of this Gospel on the subject of compassion, and this emphasis is also to be discerned in the parable of the prodigal son (Lk 15:11-32) and in other episodes which are particular to Luke (7:11-17, 36-50). Thus it is that a special source, "L," is invoked, a source perhaps used by Luke in addition to the sources which he shares with Matthew.

1. The Context in the Gospel According to St. Luke

The parable of the Good Samaritan is placed by the evangelist shortly after the beginning of a lengthy section in the Gospel which is designated "the journey towards Jerusalem." This is a section inserted by Luke between the second and third announcements of the passion of Christ (Lk 9:43-44 and 18:31-34; Mt 17:22-23 and 20:17-19; Mk 9:30-31 and 10:32-34). It goes from Luke 9:51 to Luke 18:14 and begins in the following fashion: "And now the time was drawing near for his taking away from the earth, and he turned his eyes steadfastly towards the way that led to Jerusalem." (Lk 9:51) This beginning clearly expresses the orientation towards the holy city. It is helpful to observe that the verses which follow it immediately speak about the Samaritans in order to show that this orientation provoked their hostility. "Jesus," relates Luke, "sent messengers before him, who came into a Samaritan village, to make all readiness. But the Samaritans refused to receive him, because his journey was in the direction of Jerusalem." (Luke 9:52-53).

One knows that the relationship between the Samaritan and the Jews were not of the best. The fourth Gospel describes this reality at the beginning of the meeting between Jesus and the Samaritan woman (cf. Jn 4:9).

In addition various passages from the Old Testament reveal the contempt that the Jews felt for the Samaritans who were considered bastards from every point of view, in both religious and racial terms (cf. 2 R 17:24-41; Si 50:25-26). The hostility was mutual. Thus it was that the Jewish historian Josephus writes about how the Samaritans used to trouble and disturb the Jewish pilgrims while they were on their way to Jerusalem. (*Ant*. 20, 6, 1)

It is helpful to bring to mind the refusal of hospitality which was encountered by Jesus at a village in Samaria if we want to fully appreciate the generosity that Jesus demonstrates towards the Samaritans in this parable. This generosity is expressed by the fact that he presents one of them as a model of love towards one's neighbor. Indeed, the parable is to be read in the next chapter of the Gospel and belongs to the same general section.

Jesus narrates the parable in order to answer a question posed to him by a "lawyer": "Master," he said, "what must I do to inherit eternal life?" (Lk 10:26). The same question would be asked some chapters afterwards by a very rich notable to whom Jesus replies by citing the Ten Commandments (Lk 18:18-23). Jesus does not give this particular answer to the learned man of law but makes reference instead to his personal field of expertise. "Jesus asked him, What is it that is written in the law?" (Lk 10:26). The lawyer immediately found the right answer, an answer which Jesus himself gave in a passage to be found in the other two synoptic Gospels (Mt 22:36-40; Mk 12:28-31). This answer links together the precept of love of God expounded in Deuteronomy 6:5 and that of love for one's neighbor expounded in Leviticus 19:18.

Jesus confirms the correctness of the answer and invites the learned man of law to put this answer into practice: "Thou hast answered right, he told him; do this and thou shalt find life." (Lk 10:28). The episode now seems at an end. Its conclusion corresponds exactly to its beginning and conforms to the Semitic literary procedure known as "inclusion." The doctor of law asked what he had *"to do"* to receive *"life."* Jesus said to him: *"do this and thou shalt find life."* But at this moment, and in unexpected fashion, the narrative goes off in a new direction. The learned man of law "to prove himself blameless" after asking the first question then goes on to ask another: "And who is my neighbor?." And it is the answer to this second question which provides Jesus with the opportunity to tell the story of the Good Samaritan.

2. A Change in Perspective

Biblical scholars and experts have observed that in reality Jesus does not actually answer the question

which is posed by the learned man of law. He does not really tell him who his neighbor is. Jesus does not make clear which people qualify for this category and fails to specify which other categories are not covered by this definition.

Rather than answering the question which has been posed to him, Jesus implicitly substitutes it with another, and that question is: what forms of behavior make you the neighbor of another person? The learned man of law adopts a static point of view which attempts to fix limits to the precept of love for one's neighbor. Jesus, instead, suggests a dynamic perspective to him, and this is a perspective which involves the creation of new relationships.

Diachronic exegesis has sought to discern an evident fusion of different sources in the Gospel text and has perceived in this change of perspective a reason for supposing that the parable of the Good Samaritan essentially exists independently of the account of the encounter with the learned man of law and that "it was only subsequently added to the previous context because it does not really answer the question posed by the lawyer" (J.A. Fitzmyer, *The Gospel According to Luke*, Anchor Bible, 1985, p. 883).

But a synchronic analysis of the text shows that the link between the parable and the second question of the learned man of law is essential to a correct interpretation of the Gospel story. The absence of an immediate correspondence between the answer and the question which has been asked is in very precise terms an important aspect of the teaching of the "Master" (Lk 10:25). What Jesus asks us to do is to abandon the static perspective of separations and segregations and enter instead into the dynamism of communication and communion.

We can observe that on other occasions as well Jesus provides us with answers which do not correspond to the question which has been posed to him. On the contrary, they involve passing from a theoretical question to what is an existential requirement. When one person asks him: "Lord, is it only a few who are to be saved?" Jesus does not reply by citing figures but chooses rather to make an exhortation: "Fight your way in at the narrow door..." (Lk 13:23-24). In the same way when Jesus is asked about the date of the eschatological events he has foretold he does not give a precise chronology but offers warnings instead. To the question of the disciples: "Master, when will this be?" (Lk 21:7), Jesus answers: "Take care that you do not allow anyone to deceive you. Many will come making use of my name; they will say, Here I am, the time is close a hand; do not turn aside after them." (Lk 21:8). Jesus never presented himself as a thinker or a theoretician—he always strove to communicate and achieve a dynamism of conversion and of love.

The learned man of law poses a theoretical question to Jesus: "who is my neighbor?" (Lk 10:29) Jesus answers his question by offering him a model for action and says to him, "Go on your way, and do likewise." (Lk 10:37)

3. The Answer of the Old Testament

The learned man of law could have found numerous elements by which to answer his question by looking in the Law of Moses. The meaning of the precept of Leviticus 19:18 which he himself cited is made clear by the context. The term "neighbor" is defined by a parallel phrase—"the sons of the people." Love for one's neighbor is thus understood as an attitude of solidarity with one's fellow-countrymen, and thus is very narrow in character. It is to be observed however that a few verses later Leviticus extends the concept to include foreigners (in Hebrew the word is *gèr*): "When a stranger sojourns with you in your land, you shall not do him wrong. The stranger who sojourns with you shall be to you as the native among you, and *you shall love him as yourself;* for you were strangers in the land of Egypt." (Lv 19:34). This broadening of perspective deserves attention. It is in opposition to the practice of every form of racial or national discrimination within the borders of Israel.

In the passage from Leviticus love for one's neighbor is defined with negative precepts: "You shall not oppress your neighbor or rob him." (Lv 19:13) "You shall not go up and down as a slanderer amongst your people, and you shall not stand forth against the life of your neighbor." (Lv 19:16) "You shall not hate your brother in your heart" (Lv 19:17). "You shall not take vengeance or bear any grudge against the sons of your own people" (Lv 19:18) .

Other passages from the Pentateuch, however, go beyond these negative rules and regulations. They enjoin an attitude of positive generosity towards one's neighbor. Deuteronomy requires above all else that every ten years the debts contracted by one's "neighbor" should be written off (Dt 15:2). Here "neighbor" means fellow-countrymen, as is evident from the text: "Of a foreigner (in Hebrew the word is *nokri*) you may exact it; but whatever of your is with your brother your hand shall release." (Dt 15:3). The law of Deuteronomy then dedicates itself to the condition of the poor: "If there is among you a poor man...you shall open your hand to him, and led him sufficient for his need" (Dt 15:7-8, 10). In addition, the freeing of the slaves of Israel is prescribed after a period of six years (Dt 15:12-18; cf. Jr 34:14).

The prophets themselves were much concerned with vigorous exhortations in favor of an approach involving generous solidarity. We need only here remember the eloquent appeal to be found in Isaiah, chapter 58, where God defines the

kind of fasting he wants. He is not in favor of formalistic mortifications but declares instead: "Let the oppressed go free, and to break every yoke" and "share your bread with the hungry and bring the homeless poor into your house; when you see the naked, to cover him, and not to hide yourself from your own flesh? Then shall your light break forth like the dawn." (Is 58:6-8; cf. Jr 34:8-9: Job 31:16-20, 32).

4. The Answer of Christ: "A man...."

The reply of Jesus to the learned man of law is to be understood along similar lines, but it goes much further. In truth one can asset that from more than one point of view it is provocative. The first phrase *"a man"* does not say anything. We find it at the beginning of other parables—that of the prodigal son (*"A man* had two sons," Lk 15:11), that of the dishonest steward (Lk 16:1), and that of the rich bad man (Lk 16:11).

It does not deserve special attention in these passages. But in our parable this phrase is very significant because of its indeterminate element. In answer to the learned man of law who asks him to give a definition of who his neighbor is, Jesus does not define anything at all and expresses himself in very vague terms.

The Greek word used in the Gospel—*anthropos*—does not even give an idea of gender. What comes afterwards indicates that we are talking about a male but nothing at all is said about race, religion or social rank. Is he a Jew? An immigrant? A foreigner? Is he a religious man or a non-believer? We do not know at the beginning and we do not know at the end. This shows us that in order to define who our neighbor is Jesus rejects any consideration of these categories, whatever the importance given to them by the Old Testament may be.

The only facts which are supplied to identify the person are those relating to what had happened to him and the painful situation in which he found himself. This man who went down from Jericho to Jerusalem passed through an area of desert and fell into the hands of brigands who took his clothes, wounded him and left him for dead. He was a wounded man, a man half dead—this was his identity. It is not even known if he was able to cry out or to moan.

5. The Contrast Between the Two Approaches

The parable goes on to express a strong contrast between the approach of the different people who go along the same road. Their identity, this time, is more clearly defined: we are dealing first and foremost with a Jewish priest and a Levite, and then a Samaritan. The first two figures see the wounded man but pass by on the other side of the street in order to avoid going near him. No explanation is given for this

attitude which is described very briefly with a single Greek word—*antiparelthen.* Luke here uses a word with a double suffix (*anti*—in front of, on the other side; *para*—over there) which is never found in the New Testament and is only once to be found in the Old Testament, and it is then employed with a different meaning (Wisdom 16:10).

The third person, the Samaritan, adopts a completely different attitude and approach. The first thing which is said about him, and this is when he sees the wounded man, relates to his emotional reaction—"he took pity at the sight" (literally—"he was struck in the guts" from the word *splanchnizomai* which in turn comes from the word *splanchna* meaning "guts"). This reaction, which involves pity, sets everything else in motion: rather than avoiding the wounded man as the priest and the Levite had done, the Samaritan draws near to him, he dresses his wounds, takes him to an inn and takes care of him. He then entrusts him to an inn-keeper whom he pays. He also promises that he will pay for any further expenses. One is amazed at such generosity, a generosity displayed towards somebody whom the Samaritan does not even know.

The contrast between the two approaches which are adopted in relation to the wounded man is extreme. This is also expressed in quantitative terms—only one word for the approach of the Jewish priest and the Levite but more than fifty words for that of the Samaritan. It is also expressed particularly in qualitative terms through the detailed description of the extraordinary devotion of the Samaritan. It might be thought that such generosity is difficult to believe but in actual fact it is in line with the literary character of the biblical parables. These often have unlikely features precisely because they seek to question received ideas and strive to open new and divine perspectives (cf. Is 55:8-9).

This parable clashes with the mentality of the doctor of law first of all because there is nothing legalistic about it and because, above all, it condemns the role played by such figures as the Jewish priest and the Levite, who, according to the Law of Moses are very respectable and made holy by their privileged relationship with the temple of God. And, secondly, because the parable invites the Jewish man of law to accept the Samaritan as an example to be followed, and the Samaritan, it should be stressed, is a figure whom the Bible had taught him to despise.

Jesus wants the learned man of law to undergo a radical change of mentality along the lines of Simon the Pharisee of a previous episode, that of the forgiven sinful woman (Lk 7:36-50). Jesus offers this woman who Simon despised as a model of generosity and contrasts her with the cold welcome which the Pharisee had given him. Other Gospel episodes are directed to the same end, episodes such as those when Jesus praises the faith of a pagan centurion (Mt 8:5-13; Lk 7:1-10) or when he says to the scribes

and elders: "the publicans and the harlots are further on the road to God's kingdom than you." (Mt 21:31). Like the Old Testament prophets (cf. Is 1:3; Ezk 16:48-51; 22:4; 23:11), Jesus in this way mounts telling and incisive challenges to his people in order to foster and promote authentic spiritual development within them.

6. Two Different Concepts of Holiness

No explanation, we have observed, is given in the parable for the attitude and approach of the Jewish priest and the Levite. Why do they not draw near to the wounded man? Why do they pass by on the other side of the road? Why does Jesus cast these respectable figures in a very bad light?

In trying to solve these problems bible scholars have suggested that the most plausible explanation is to be found in concern over ritual purity. The Law of Moses required ritual purity for every act of participation in ceremonial worship. The smallest contact with a dead person could lead to this purity being lost. The Law declares: "He who touches the dead body of any person shall be unclean seven days" (Num 19:11). To have participated in ceremonial worship would have amounted to a profanation of the House of the Lord and would have involved the punishment of being "cut off from Israel" (Num 19:13). For the priests the law of purity was especially strict. It should be pointed out that the Book of Leviticus devotes an entire chapter to the subject (Lv 21).

There are thus good reasons for supposing that the attitude of the priest and the Levite described in the parable was the result of concern over ritual purity. If they had attended to the unfortunate traveler who had been left "half dead" at the side of the road, they would have risked holding him in their arms whilst he died, an event which would have led them to have contracted a very serious impurity which was incompatible with their priestly "holiness."

The implicit lesson offered by the parable, therefore, might be that "mercy" towards the victims of misfortune must take precedence over concerns about ritual purity. This lesson corresponds in effective terms to a constant orientation and central feature of Gospel teaching. By his words and even more by his example, Jesus made clear that God prefers a generous attitude towards one's neighbor to ritual worship. In the first Gospel Jesus interprets the words of the prophet Hosea where God says: "For I desire steadfast love (the Jewish word is *hèsèd*) and not sacrifice" (Hos 6:6; Mt 9:13; 12:7) along these lines. In the same way a polemic sustained by Jesus against exaggerated concern with ritual purity is dwelt upon at length by Mark and Matthew (Mk 7:1-23; Mt

15:1-20). The same is done, albeit in more moderate form, in Luke (Lk 11:38-41).

All three of the synoptic Gospels (but more emphatically in Luke) involve a relativization of the precept about the sabbath day. To the episodes which are described involving the ears of corn (Mt 12:1-8; Mk 2:23-28; Lk 6:1-5) and the healing of the hand on the sabbath day (Mt 12:9-14; Mk 3:1-6; Lk 6:6-11), Luke adds the story of the healing of the woman bent double (Lk 13:10-17) and the healing of the man with dropsy (Lk 14:1-6). The lesson is always the same: the urgent need to help one's neighbor has greater importance in the eyes of God than the observation of the sabbath rest day.

In all these cases it is to be observed that Jesus ceaselessly calls for a change of perspective. This change, he stresses, had been prepared for by the teachings of the prophets (Is 1:10-17; Jr 7:1-7; Am 5:21-24). It involves substituting the search for holiness through segregational observation with holiness obtained through generous solidarity. Ritual purity is not enough to achieve an authentic relationship with God. What is needed is to place oneself at the service of God through service to one's neighbor and to allow oneself to be moved by the force of divine mercy which seeks to reach people who suffer and are in need of care—the wounded, the sick, the handicapped, and the despised. The parable of the Good Samaritan expresses this movement in two ways. On the one hand it describes the generous attitude and approach of the Good Samaritan to the wounded traveler and on the other it provokes admiration for the Samaritan himself, a member of a population which is traditionally the object of contempt.

7. A Model to Follow

In conclusion we can observe that our parable belongs to a very special category of parables which Adolf Jülicher has termed "example-tales" (*Beispielerzählungen*). Rather than describing the Kingdom of God through analogy, as is the case with the parable of the sower or of the hidden treasure, the example-tales describe a fact which illustrates a teaching in direct and immediate fashion. Such is the case with the "parables" (Lk 12:16) of the foolish wise man, of Lazarus and of the bad rich man (Lk 16:19-31), and of the pharisee and the publican (Lk 18:9-14). In this category of parables the Gospel of the Good Samaritan occupies a special position because it is the only parable which has a direct invitation to follow the example which has been held up by the teller. Evidently enough, the foolish rich man, the bad rich man or the prayer of the Pharisee are not examples to be followed. The prayer of the publican is such an example but the Gospel does not say this explicitly and merely allows it to be understood.

The Gospel of the Good Samari-

tan on the other hand concludes with these words of Jesus: "Go on your way, and do likewise" (Lk 10:37). In many other parables the term "bear a likeness to" (from the Greek *homoios*) comes at the beginning in order to introduce the comparison: "What is there that bears a likeness to the kingdom of heaven; what comparison shall I find for it? It is like a grain of mustard seed, that a man has taken and planted in his garden" (Lk 13:18; see also Mt 13:31; Lk 13:21; Mt 13:33, etc.). In the Gospel of the Good Samaritan, which is unique in its kind, the expression "likewise" comes at the end. It is the last word. By accompanying a command it defines a rule of action and shows that the tale which has just been narrated offers a model to be followed.

This model is the Samaritan who was moved by the sight of the half-dead man and expressed his compassion through a generous action. His "mercy" was not a mere sterile sentiment but was effectively translated into action. The Good Samaritan is he "who had pity" and it is in these terms that he is described in the answer to the question of the learned man of law (Lk 10:37).

The same Greek expression (*poiein eleos*) is to be found on only one other occasion in the New Testament, and more precisely in another passage from the same Gospel. It is applied to God himself (Lk 1:72) and forms a literary "inclusion" with the expression "the merciful kindness of our God" (Lk 1:78). By being moved (cf. Lk 10:33) and practicing mercy (Cf Lk 10:37) the Samaritan thus made himself resemble God (Cf Lk 6:36; Eph 5:1-2; Col 3:12). He did not ask the question: "Is this man my neighbor? Am I obliged to love him?." On the contrary, he took the initiative of drawing near to him (cf. Lk 10:34), of caring about him, and he thereby became his neighbor in unequivocal fashion (cf. Lk 10:36-37).

8. Conclusion

This, then, is how Jesus answered the learned man of law according to the Gospel of Luke. He refused to enter into a legal discussion about the definition of the word "neighbor" and thereby gave a strong impulse to the lawyer to become the neighbor of each and every human person. For over nineteen centuries the Gospel of the Good Samaritan has not failed to communicate the same impulse to those who have reflected upon it. The Good Samaritan also wants to communicate this impulse to us, here, in this international conference, which defines its orientation and direction by reproposing the final words of Jesus: "*Vade et tu fac similiter,*" "Go on your way, and do likewise."

Rev. ALBERT VANHOYE, SJ
Secretary of the Pontifical Biblical Commission,
Professor of the Pontifical Biblical Institute, Rome

IGNACIO CARRASCO DE PAULA

The Good Samaritan as an Anthropological Category

Because the title of this paper is open to a large number of interpretations and because it would be impossible to do justice to them all, it would be helpful to begin with a premise which sets out the parameters of the analysis which I will present in this paper. This year's international conference has chosen to discuss the relationship between the Good Samaritan and Hippocrates from the point of view of a historical and doctrinal inheritance which has been able to perceive complementary elements in the Hippocratic ethos and in the Gospel model, elements humanizing and completing each other. Whoever follows in the footsteps of the pilgrim of Samaria does not draw away from proximity to Hippocrates. On the contrary, that pilgrim comes to understand his meaning and brings Hippocrates to his highest point of perfection. Having outlined these considerations I would now like to pose two questions.

1. Two Preliminary Questions

The first question is, How can we define the relationship between the two approaches represented by Hippocrates and the Good Samaritan in rigorous rational terms? Does the implicit complementary character of the two figures correspond merely to a simple –albeit by no means casual— agreement on ends which must be achieved? Are we dealing here with an extrinsic relationship which arises from contingent circumstances? Or do we have before us a convergence which rests upon solid and lasting bases? To employ an image dear to Maritain, could the Good Samaritan be seen as a cap which decks out the Hippocratic shirt or a hat which can be left behind if circumstances or convenience so require?

From what has been said over the last few days, I believe that a unanimous answer has already been given: the Gospel model cannot be reduced to a mere optional element even though it may well be possible to ignore it or degrade it to a merely secondary role. I myself also propose to maintain this second thesis because I believe that it conforms more to truth than does its counterpart.[1] *The second* question, to continue on with the image borrowed from Maritain, is that it seems reasonable to suppose that when the medical doctor has finished his work in the hospital or in his private office, he goes back to being an ordinary citizen and takes off those clothes which tell the outside world what his profession actually is. Now, is it right and possible to carry out the same operation in relation to what those clothes represent? This question leads directly to another: To what extent does the medical *ethos* affect the personality and influence the behavior of the health care worker?

At first glance common sense would seem to require a simple answer: when the medical doctor, whether man or woman, returns home, the intimate concerns of wives, husbands, and children cannot be listened to in the same way as patients are listened to; the actions of close relatives cannot be observed with the same analytical attention with which a sick person is examined. At home the hat and the shirt have to be hung up when the threshold is crossed.

And yet things are not so simple as that. And here we have to introduce the anthropological category.

2. Categories as Expressions of Being

The concept of category in its original meaning comes from a Greek term meaning 'declare,' 'demonstrate.' Categories are a way of expressing being in the irreducible peculiarity and variety in which being manifests itself. Categories underline diversity at a primordial level, and in doing this they are set against transcendental realities, which, in opposing and contrary fashion, indicate ways of being which are common to everybody: each existing being, by the very fact of existing, is good, is true, and so forth. Let us here leave aside the hermeneutic problem raised by two opposing schools led by Aristotle and Kant. Here we need only affirm that an anthropological category is nothing but the enunciation of a way of being man.

An example can be given of this. The figure of the father is a classic model of an anthropological category. The idea of the parent, in fact, evokes a particular way of being and behaving. Parenthood arises and manifests itself in opposition to another anthropological category, that of the child. Neither the parent nor the child is to be traced back to another event or a previous experience. And for this reason they are charcteristic elements distinguishing who a parent is and who a child is, as opposed to somebody who is not a parent or a child.[2]

Although the relational dimension provides clear and precise contours of the categories of parent and child, mere rationality is not enough to give these figures validity. The relationships involved are manifold. A person who buys a newspaper establishes a relationship with the newspaper seller, but it is rather unlikely that he will consider the newspaper seller as belonging to a specific anthropological category. In this case the relationships are confined to the provision of a service, something which is thus contingent. An anthropological

category, to be such, requires, moreover, stability, a stability which is at the same time required and guaranteed by its being rooted in being. In a certain sense the parent is in this condition before the existence of the child and will continue to be so even if illness were to carry off the child. One is a parent not only through *action*—that is, when one behaves as a parent, but because of the ontological structure of one's own being.

One final observation to complete and clarify what I am proposing. Parenthood can be preached to every person. Every man and every woman has a connatural disposition towards fatherhood or motherhood. Obviously enough, I am not referring here to the essential procreative power of the physical structure, and even less to effective fertility. I am referring, rather, to an anthropological dimension, to a true constituted being who can only be neglected at a very heavy price. This also holds good for those who decide not to generate other individuals out of a higher motive. Indeed, such people can only translate the anthropological character of father/mother into spiritual fatherhood or motherhood.

3. The Medical Doctor as an Anthropological Category

I have dwelt upon this model, which is well known to everybody, not so much because the figure of the father and the figure of the doctor have many elements in common,[3] but, rather, in order to give a clearer idea of the path I propose to follow to evaluate and assess the relevance of the Good Samaritan as an anthropological category. However, before directing our attention to the parable narrated by Christ, we must examine whether a disciple of Hippocrates really has valid grounds for aspiring to such a status.

It seems incontestable that the figure of the medical doctor cannot be traced back to a previous model. He has his own specific characteristics: a way of being a man at the service of other men based upon a relationship of opposition to the illness which threatens their humanity and places the subject in another category—that of the patient or sick person. But we still have to discover the anchorage of this in the being of the person. In surprising fashion the parable of the Good Samaritan comes to our aid. We do not know who the Good Samaritan was. It is certain that he did not go to Jerusalem for religious or sightseeing reasons. He was probably a merchant or trader. He is able, however, to supply a kind of first aid. Indeed, he applies a treatment and orders the rest and recovery in an inn of a man who is seriously wounded.

The practice of medicine requires a specific training, but each one of us knows that in the must unexpected moment we could find ourselves in a situation where we have to improvise the role of health care worker to help our neighbor. In all of us there is a radical readiness to serve life and health. One could say that each one of us carries a little doctor within himself. Whether this presence is operative or not is quite another question. The role of the medical doctor, therefore, fulfills all the requisites necessary to belong to an anthropological category. But is the model of the Good Samaritan a good way by which to define this category?[4]

4. The Anthropological Structure of the Model of the Good Samaritan

The first indications which emerge from a reading of the parable of the Good Samaritan lead to a negative response. The question asked of our Lord does not concern the approach which should be adopted towards a sick person. It is not a question about how the sufferings of a patient should be alleviated. Moreover, it does not ask for advice in relation to matters of professional ethics. The question deals, rather, with the following problem: *Who are the individuals that I must love as myself*? Who is my *neighbor*? It is taken for granted that not all men are worthy of my love, and for this reason Jesus is asked to indicate and describe the signs or the conditions which would enable us to recognize those people who are deserving of such an elevated form of love.

Furthermore, the answer of the Master is not evasive, it does not dodge the question which has been posed. Indeed, it seeks to give full satisfaction to the questioner. Christ does not want to direct the argument into the subject of doctors or medicine. He wants to show that "special" conditions which act to render people worthy of love do not exist. The fact of existing and of being met is enough. Now, although love does not know categories, the individual who loves does: he can become a "neighbor" or an "alien." In order to illustrate this antinomy, society provides a number of examples—a judge, a wealthy benefactor, a master or a guide, and so forth. However, the Lord chooses a traveler who found himself in the unusual situation of having to provide first aid to a dying man. Without forcing our interpretation of the parable, there are good reasons for thinking that the Lord found a particularly effective meaning in the action of taking care of someone in danger of dying by which to illustrate how relationships between men should really be. The Good Samaritan engages in a medical action and at the same time furnishes an indicative sign of humanity—care for the sick, for the suffering, for the abandoned.

The Good Samaritan represents a specific model for behavior. The parable speaks about a priest and a Levite precisely in order to compare these two figures to the traveler who comes after them. The impression which we gain is that the list could be even longer—a politician, a soldier, a merchant, a scribe, and so on. But this would be at the cost of making the story unnecessarily heavy. The two individuals devoted to worship are enough. The Gospel does not explain the reasons for their behavior even though we could give some very good guesses.[5] However, what is important here is not the ethical judgment which excuses or condemns the act of omission on the part of the priest or the Levite, but the fact that men can be divided into two categories: those that are prepared to become "neighbors" and those that are not. Obviously enough, to become a "neighbor" we do not have to pour out wine or oil or spend money. And yet by acting in this way the Good Samaritan makes himself a "neighbor" and at the same time demonstrates a way of being and living which is human in the fullest sense of the term.

In order to complete these reflections I would once again draw attention to a key feature of this anthropological category: the ability to perceive the unfortunate person and the situation he is in. What did the traveler from Samaria see which the others had not seen? The man? The wounds? The need...? All these elements were more than obvious, and to such an extent that the priest and the Levite avoided being involved in the affair. The Good Samaritan perceived something more—that is, a

man who should be loved as we love ourselves, and without any conditions: he felt himself called upon by a person who was worthy of infinite love.

5. A Response to Some Critical Observations

We cannot conclude these reflections without referring to some critical observations which have been made. In practical terms I am thinking here of the observations made by Childress,[6] one of the most significant experts on bioethics in the United States of America. This writer believes that the model of the Good Samaritan is an inadequate model because it does not give answers to all the possible situations which involve a doctor and his patient. It is suggested that the charity which can lead him to treat the victim would not leave room for justice. Indeed, one could even doubt the ethical validity of his behavior because he takes immediate action without informing himself beforehand about the wishes, the preferences, or will of the individual concerned. The approach of the Good Samaritan is said to be disrespectful in relation to the independence of that poor man. I think that this criticism gives some idea of the narrowness of mind with which Childress—who in his other writings is a careful and rigorous author—approaches the parable of the Good Samaritan.

Furthermore, the author wonders what the Good Samaritan would have done if he had encountered a number of men rather than just one individual. How would he have allocated his resources, the wine and oil he had available, the money to pay for the inn as long, that is, as it was possible to find a bed for each person? This also, it is suggested, would have constituted a limitation on his actions, or at least a problem which would have remained unsolved.

Our critic concludes by arguing that we do not know what the Good Samaritan would have done if the robbers had returned while he was attending to the wounds of the man left for dead. Would he have attacked them to defend his own life and that of his neighbor? Or would he have treated the thieves as his neighbors?

Let us leave aside the fact—ignored by Childress—that when emphasis is placed on the primary importance of charity, this does not necessarily mean that the indispensable role of justice is denied. Whether or not his observations are relevant (and I would say that they are not), we should indeed seek to understand the substance of these objections, quite apart from the literal approach employed by Childress.

It seems to me that his reading of the parable does not help us in our search for its anthropological meaning. His reading is of use in the formulation of rules and the provision of solutions in relation to the very many dilemmas which now present themselves both inside and outside the world of medical ethics. What should the Samaritan have done if the robbers had returned to the site of the crime? What should a doctor do at Sarajevo when bombs are raining down? These questions do not belong to the specific category of the profession. In basic terms, the medical doctor would do that which a school teacher or a hotel keeper (and the list does not end here) would do. The question is meaningful only if posed to a military man.

The anthropological category represented by the Good Samaritan does not constitute an instrument by which to analyze medical reality in order to obtain practical results. It is a means by which to achieve a suitable description of the way in which humanity—or the program of humanity which is present in each and every person—is achieved in those who commit themselves professionally to that area of extraordinary richness and complexity which is the life and health of man. Considered overall, the Good Samaritan behaves very well, both as a medical doctor and as a man. By practicing medicine by pure chance he becomes a neighbor to someone and in so doing he loves others as unconditionally as he loves himself.

We have before us an anthropological category which never ceases to amaze us.

Monsignor IGNACIO CARRASCO DE PAULA
Member of the Pontifical Academy for Life,
Professor of Moral Theology at the Roman Atheneum of the Holy Cross,
Consultor to the Pontifical Council for Pastoral Assistance to Health Care Workers

Notes

[1] As *Evangelium Vitae* implicitly reveals, Hippocrates, although pagan, has not been able to obtain the respect of a culture which denies the existence of any relationship between the divine and the human. Indeed, the Hippocratic Oath has been eliminated from most codes of medical ethics.

[2] Parenthood necessarily implies the existence of a specific role—that of having generated another human being and of having taken on oneself the task and the responsibility of providing for, and taking care of, the growth and upbringing of that human being.

[3] This nearness conceals a danger observed by modern criticism—the transfer *tout court* of the parental model to the role of the medical doctor, something which gives rise to the much deprecated (perhaps overly deprecated) phenomenon of *paternalism*.

[4] The motives which lie behind this behavior of the Good

Samaritans do not of themselves allow us to create a category. Charity is the substance of the parable. But charity is not an anthropological category it is a virtue. Charity penetrates the whole of man and not an aspect or a particular area of his being and his acting.

[5] The priest ran the risk of rendering himself unable to take part in ceremonial worship.

[6] SEE J.F. CHILDRESS, *"Amore e Giustizia nell"Etica Biomedica Cristiana"*, in E. E. Shelp (ed.), *Teologia e Bioetica* (Edizioni Dehoniane, Bologna, 1989), pp. 355-382.

ANGELO BRUSCO

The Model of the Good Samaritan in the History of Hospital Care

Jesus Christ is the fulfilled model of the *Good Samaritan*, and this model is offered to us not only in the parable in the Gospel according to St. Luke but also in the texts of the Holy Scriptures taken as a whole. The principal features of this model can be summarized as follows:

– He is a wounded healer, that is to say a person who can turn his own suffering into a source of healing for other people. As the prophet Isaiah declares: "Surely he has borne our griefs and carried our sorrows; yet we esteemed him stricken, smitten by God, and afflicted. But he was wounded for our transgressions, he was bruised form our iniquities; upon him was the chastisement that made us whole, and with his stripes we are healed" (*Is* 53:4-5).

– He takes the initiative, that is to say *he goes* towards those who suffer.

– He is capable of compassion and giving welcome.

– He is not influenced by prejudices about the race, the culture, or the social class of the sick person.

– In his approach to things, *health and salvation* are closely correlated.

– Commitment to serving the sick person can also involve the giving of his own life.

Down through the centuries how has this model—which was incarnated in the person and the actions of Jesus Christ—been put into practice?

Each of the features outlined above has found concrete expression, or at least partially, during each period of history. This is not to deny, however, that different historical moments have witnessed the expression of these features in very special forms.

This is what I will try to demonstrate during the course of this brief paper.

1. The Pre-Christian Period

We can detect the presence of numerous features of the model of the Good Samaritan which has been outlined above in the history of care provided by health care institutions during the period which preceded the birth of Christ.

The Wounded Healer

The metaphor of the "wounded healer" arose in ancient Greece and served to indicate that those who care for the sick should first look to their own wounds and understand them within the context of their own experience. The freedom to draw near to sick people with compassion for their suffering, and with participation in their suffering, springs from this process of self-healing.

The myth of Aesculapius is very illustrative here. The son of Apollo and Coronis, he was wounded even before he was born. What had happened was that his mother had been unfaithful to Apollo and had been wounded by an arrow fired by Artemides while she was still pregnant with Aesculapius. She had also been condemned to die by fire. When Coronis was on the pyre, Apollo took Aesculapius from his mother's womb and thus saved him from the flames. The upbringing of the baby was then entrusted to the centaur Chiron who practiced the art of healing. Chiron suffered from an incurable wound which Hercules had inflicted upon him. A healer in need of healing thus taught Aesculapius the art of healing, that is to say the ability to find himself 'at home' in the darkness of suffering and to find in that darkness the seeds of light and of healing[1].

A Sense of Humanity

In the Greek and Roman hospitals (the *asclepiei*, the *iatreia*, the *valetudinari*, the *medicatrine*) there were moving expressions of love towards one's suffering neighbor. We know of many examples of altruism infused with an attempt to combine efficiency with compassion. There were also evident efforts to overcome the barriers of social class. The use of religion in the process of healing was also often present. The influence of such great figures as Hippocrates and Galenus, and of the Greek schools, helped to create a medical and health care culture in which major emphasis was placed upon the idea of complete health and upon such important moral values as respect for the individual and his life.[2]

In the general context of Greek and Roman health care, however, there were certainly negative elements which worked against the model of the Good Samaritan.

The Unhealthy Use of Religion

Because of its close connections with religion and because of the inadequacy of existing medical scientific and technological knowledge, health care was often influenced in a negative fashion by superstition, by witchcraft, and by charlatanry. Those responsible for religion could easily become manipulators of the sick and could exploit the suffering of the sick to their own material advantage.

"The healers gained a great deal from their art both in terms of money and gifts. There was even a real and authentic commercial association of these healers who joined together in organized form. The sick customer of a rather gullible character was invited to one temple after another and was expected to leave a large gift of money or goods in each. The way in which these astute healers worked

their treatment was the object of satirical criticism by Lucian in his *Shop of the Gods* and by Aristophanes in the comedy *Pluto*."[3]

2. The Christian Period

In a document of the third century after Christ we can detect certain characteristics of the transition from pagan to Christian culture. This document is made up of a number of verses from a poem on the duties of the physician. The disciple of Aesculapius, it is asserted, "should be similar to God: the savior equally of slaves, poor people, the rich, princes...and he should help them all, being brother to them all. He should not hate anybody, nor nurse envy within his heart, nor inordinately raise his fees." How can one fail to find in these words an echo of the Gospels?[4]

In the Apostolic Exhortation *Christifedeles Laici* one reads the following lines:

"The Christian community has written anew, down the centuries, the evangelical parable of the Good Samaritan, and has revealed and communicated the love for healing and consolation of Jesus Christ. This has taken place through the witness of religious life consecrated to service to the sick and through the untiring commitment of all health care workers" (no. 35).

We can detect various periods in this writing anew of the gospel parable and the consequent imitation of the Good Samaritan, and we can perceive elements which have emerged with especial prominence.

a) Before the French Revolution

It has been historically demonstrated that until the French Revolution, and even beyond, care for the sick took place under the impulse of Christian doctrine. Even when government and other non-religious bodies took on the responsibility of building and managing hospitals, they were guided by gospel principles which found their most complete expression in the figure of the Good Samaritan.

The aspects of the model of the *Good Samaritan* which emerged most prominently during this long period were as follows.

Hospitality

This aspect of the Gospel text is expressed in the meaning itself of the term "hospital" and has bestowed honor upon health care institutions. Such great physicians as St. John Chrysostomus, St. Gregory of Nyssa, St. Basil, St. Clement of Alexandria (in the East), and St. Ambrose, St. Augustine, St. Cesarius of Arles, St. Gregory the Great (in the West), dedicated great importance to the value of hospitality. The term *Hotel-Dieu* given to hospitals in France and its colonies in Canada clearly expressed the evangelical character of the welcome given by the Lord to the poor and the sick.

The monasteries also gave a notable impulse to this hospitality, and were also major centers of learning and charity. We can not fail to see in this fact a convergence of Christian mission—practiced by bishops, members of religious orders and the lay faithful—with attendance to the needs of the poor and the dispossessed.[5]

One saint, and more particularly St. John of God, received and practiced the value of hospitality and made it an instrument of the redemptive love of Christ towards those who live the difficult season of poverty or suffering. The Hospitaller Order which was established by St. John of God added the vow of hospitality to the three traditional and conventional religious vows.

The Overall Approach to the Sick Person

The approach to the sick person in the entirety of his being—his body, spirit and soul—is rooted in the ministry itself of Christ. The attitude of the Good Samaritan has never been forgotten as a way of life. However there have been people who have used this as the basis for a program in such an intense fashion they have become veritable founding fathers in this area. One of these figures was St. Camillus De Lellis. When proclaiming his canonization, Benedict XIV declared that he was the founder of a "new school of charity." One of the aspects of the newness of his approach lay in the importance he gave within the health care project to all the needs of the sick person, whether physical, emotional, social or spiritual.

Does this not lead us to reflect on the fact that today great effort is devoted to promoting a "holistic" or overall approach to health care both in relation to medicine and with regard to nursing?

Emotional Involvement

Given that the sick person must be cared for in his entirety, the health care worker must commit himself completely and must add "heart" to scientific knowledge and action. "More heart in those hands!" was one of the injunctions that St. Camillus De Lellis gave to health care workers. He also wrote down the following rule:

"First of all each person should ask the Lord to give him the grace of maternal affection to his neighbor so that he can serve him in all charity, both in soul and body. This is because we want, through the grace of God, to care for all sick people with that affection which a loving mother gives towards her sick only child."[6]

And who can ignore the immense contribution given to health care by the foundation of the Daughters of Charity by St. Vincent De Paul? They were "some of the first to consecrate themselves to God outside the convent walls." These nuns have given greater prominence to the female face in the corridors of hospitals, a face made up of tenderness and of compassion.

The Giving of Oneself, Even to the Point of Martyrdom

This is as aspect of the model of the Good Samaritan which has shone with great light during the history of health care. The history of the Church contains a large number of men and women who have sacrificed

their lives caring for people who were afflicted with infectious diseases. They thereby showed that "devotion to the point of martyrdom is one of the principal aspects of the prophetic character of Christian life and in particular of the life of those who belong to religious orders."[7] The plague of 251 AD, when St. Cyprian displayed great holiness; the plague which devastated half of Medieval Europe; the pestilence of the sixteenth century which witnessed the actions of St. Charles Borromeo; and the numerous outbreaks of infectious diseases have all had a great impact upon thousands and thousands of believers. They have seen how the performance of service even at the risk to one's own life can involve the fulfillment of an individual's Christian and human vocation through the following of the example of Christ, the divine Samaritan, the physician of souls and bodies.

At the same time certain deformations of the model of the Good Samaritan are easily detected during this period.

The Decline of Hospital Facilities

The causes of this phenomenon are to be attributed to maladministration, corruption, and failure to live up to the ideals which had inspired the foundation of the hospitals. Indeed, the cultural shift from the Medieval period to the Renaissance was not without a certain negative influence upon the systems of values which governed health care, as can be understood from certain descriptions of what happened to Roman hospitals during the sixteenth century.

Lack of Respect for the Religious and Moral Beliefs of Sick People

Sick people were forced to receive the sacraments as a pre-condition to their being treated. There were few examples of opposition to this practice (St. Camillus was a rather lone voice) which, unfortunately, continued to exist until the nineteenth century in the hospitals run by the Church.

The Crisis of Spiritual Care

This crisis took place during the sixteenth, seventeenth, eighteenth, and nineteenth centuries, and is also to be found in the health care institutions managed by the hospitaller orders. The hospital became a place upon which priests turned their backs. As one historian from the seventeenth century puts it: "The hospitals were so hated and looked down upon by men of a certain position that priests did not want to go there whatever was offered them. It often happened that the bishops and other gentlemen of the hospitals were forced to use the scum of the earth, that is to say ignorant, outlawed or prosecuted ministers, and placed them in these places under penitence or punishment."[8] Similar things are said by authors writing during subsequent centuries.[9]

b) From the French Revolution to the Present Day

The Enlightenment led to great reforms in the health care field. In large part these sprang from the taking of hospitals out of the hands of the religious orders, a process which although not unknown in the past during this period took on an irreversible force. The state was encouraged to become responsible for the health care structures. Differently to what had happened previously, the Enlightenment and above all else the French Revolution involved the placing of health care institutions in non-religious hands in a way that was linked to a departure from the Christian vision of man. The Enlightenment's dream that illness and death could be weakened penetrated the culture of the modern health care world and was promoted by the enormous advances achieved by science and medical technology. This process created great hopes but also provoked dramatic disappointments.

What happened to the model of the Good Samaritan during this period? The salient features of the story can be outlined as follows:

Technology as an Instrument of Charity

There can be no doubt that the overt aim of technology is to humanize. One need only think here of the ability to prolong lifespan, to reduce suffering, and to improve the quality of the social role of individuals. The use of ever more sophisticated machines and instruments offers patients new chances of being cured, an expanded number of alternative ways of being treated, and greater opportunities of communication. From this point of view, technology can be seen as a modern and effective instrument for the expression of humanism and charity, as is evident from the founding charter of the Sisters of Charity of St. Vincent De Paul. It is clear, therefore, that the Good Samaritan of modern times also dwells in the new temples of medical technology, cooperating thereby in the creative and redemptive action of the Lord.

The Rationalization of Administration

The rational organization of work has favored real human progress and the sound administration of a health care institution is the expression of genuine charity. The great hospital saints provide a good example of this. St. John of God was discharged from a hospital where he had been treated and then proceeded "to found another which was alternative to the public service but not in competition with it in order to demonstrate at a practical level that it was possible to provide everybody with health care which was worthy of the human person, a health care based upon competence, solidarity, and upon solidarity at the service of love. His direction followed new and up-to-date criteria some of which were well before their time"[10]. The same impression is gained from a reading of the "Orders and methods to be followed in hospitals to serve the sick poor" composed by St. Camillus.[11]

The modern administrator is a Good Samaritan when amid the "papers, tasks, and ever more complicated machines" of his office he knows how to keep the spirit of giving within his heart and he has the

strong conviction that at the center of his work is to be found Christ present within a sick person. Who has not been led, in a state of constant spiritual tension, to ask himself the following questions:

"Does this work really respond to present-day needs? What should be the relationship between the human criteria of profit and prestige and the healthy criteria of realism not devoid of an element of trust in providence? How can we give practical expression to the Church's choice in favor of the poor and the marginalized without falling into acts of discrimination? Is the administrative dimension of what is done both right and open to compassion as an essential part of the complex human condition? Does it set a good and constructive example for the present and the future? Is it integrated into the Church community? Does it have sound relationships with parallel initiatives taken as a whole? Is there a clear sense of the transient character of everything which is human?[12]

Humanization

The Good Samaritan of modern times carries out his mission through a humanization of the world of health and suffering.[13] Although scientific and technological progress in the sphere of medicine and in relation to administration has brought great advantages, it has also given rise to, and still gives rise to, serious disadvantages.

The difficult side of the application of technology to health care and treatment is to be found in the fact that this can involve neglect of man at the very moment when an attempt is made to heal him. We could think here, for example, of everything connected with 'therapeutic overkill'. On the one hand, there is the employment of very advanced technological methods to keep the patient alive, and, on the other, there is a lack of attention paid to the value of the dignity of the individual and to respect for the individual.

Another example is to be found in cases where suffering is treated in a merely technological fashion, that is to say without any consideration of the fact that suffering is experienced by a person who feels its repercussions at all levels of his being. The illness is treated but the man is not and for this reason the health approach is often merely a clinical approach which is ascetic, cold and distant in character.

In relation to administration in the health sphere, we need only think of the bureaucratization of the systems of service, a process which easily engenders apathy, routine, resistance to change, and errors at the level of communication. Specialization and standardization in work and behavior are often useful in creating greater efficiency but when they are carried to an extreme, which indeed often happens (not least because of the demands of trade unions), it becomes difficult to respond in a personal way to the problems of the sick

person which are of a very individual character because of their specific nature and their emotional dimension.

The bureaucratization of services, for example, has contributed to a move from the predominance of primary and family relationships to the preponderance of functional relationships which have become ever more impersonal. In the functional relationship the other person is not seen as an individual but merely as a unit which furnishes or receives services. Attachment, interest and love tend to be substituted by the cold laws of a contract of work. It seems the case that compassion, identification with those who suffer, and personal involvement, are not encouraged by the health service system. We are led to ask ourselves about the extent to which the administrative apparatus can really be animated by human values. The words of one administrator are very relevant here:

"For a long time now the need has been proclaimed, and quite rightly, for a humanization of hospital health care, but we might ask if the debate has also involved reference to the humanization of hospital administration. Those who work in constant contact with those who suffer are generally helped in finding out what the inhuman aspects of their behavior really are. But those who work in the administrative sphere are more subject to the risk of quantifying the sick, of thinking more in terms of bed space and meals available than in terms of suffering people, and of giving an absolute character to their role and thereby closing themselves to renewal, to dialogue, and to cooperation."[14]

When administration is humanized it can itself become a source of humanization:

"The support of an input of humanity which should animate all those who work together is a part, in fact, of healthy and humanizing administration. This is especially true in situations where it is necessary to create a climate of cooperation, respect differences of opinion, and work together in a group. Humanity creates humanity and from the administration in the hands of a member of religious orders there should flow out that humanity and affection which are aimed at reaching the patient and his environment."

How can we forget that refrain sung by the Genoese on the death of St. Catherine of Genoa? "But look: in Genoa—a saint amongst the administrators. So we also have a chance, don't we." The saint lived during the second part of the fifteenth century and spent most of her years serving the poor, thereby becoming poor herself.

The Defense of Life and of the Individual

In the Encyclical *Evangelium Vitae* this aspect of the Good Samaritan of modern times is well brought out. He strives to ensure that within the health care world the logic of technology does not triumph over the logic of ethics, and that the dignity of human fragility is respected, as is necessary when man is afflicted by physical or mental woes. Pain, illness and death are a part of life. There cannot be growth without suffering, and suffering can be transformed into an opportunity to achieve growth.

The ethical dimension to service to life and the sick is not confined to the field of research but also includes care at both a medical and an administrative level. Administration, indeed, should be based upon the moral values of justice, equity, respect for the sick and those who are dependent upon them, the investment and distribution of resources, and so forth.

Evangelization: Health and Salvation

The move from a society which is cohesively Christian to a society which is culturally, ethically, and religiously pluralistic has given new importance to the need to link health and salvation together in an effective fashion, taking the work of Christ as a point of departure. The Christian health care institutions and the professional health associations seek to promote overall health which even touches upon the transcendental dimension. Who could underestimate the importance of this aspect of the *Good Samaritan?*

On the Side of the Poor and the Least

This aspect of the Good Samaritan has always been present down the ages. It is a part of the mission of man, not only of the Church. For believers it is an inescapable imperative and an integral part of faith. In modern times it has taken on an especial importance because of the great injustices which prevent a just distribution of obtaining good health. There is an ever increasing number of marginalized people, victims of selfishness, violence and injustice to be found in the way of progress. They go under a variety of names—lepers, AIDS victims, drug-addicts, the dying, the chronically ill. A great many Good Samaritans, whether professionals or volunteers, come to the aid of this suffering humanity. Mother Theresa of Calcutta is a name which symbolizes many of these Good Samaritans.

Conclusion

What will be the dominant features of the Good Samaritan during the post-modern era? This is an era characterized by weak thought, an era which trivializes reality and events such as death and birth. It is resistant to the idea of accepting pain as a component part of human experience, but it is also rich in positive resources such as solidarity and the thirst for a better world.[15]

The answer lies in the essential component element of the model of the Good Samaritan—love. All of us are called to this approach of the mind and the heart, as indeed is well pointed out by the already mentioned Apostolic Exhortation *Christifideles Laici*:

"Today there is an increase in the presence of lay women and men in Catholic hospital and healthcare institutions. At times the lay faithful's presence in these institutions is total and exclusive. It is to just such people—doctors, nurses, other healthcare workers, volunteers—that the call becomes the living sign of Jesus Christ and his Church in showing love towards the sick and suffering" (no. 53).

Rev. ANGELO BRUSCO, MI
Superior General of the Ministers of the Sick (Camillians), Italy
Member of the Pontifical Council for Pastoral Assistance to Health Care Workers

Notes

[1] Cf. A. BRUSCO, *"Vulnerabilità Personale e Servizio agli Infermi,"* in *Camillianum*, 8, 1993, pp. 223-242.
[2] Cf. D. CASERA, *Chiesa e Salute* (Ancora, Milan, 1991), pp. 9- 14.
[3] A. CASERA, *L'Ospedale e l'Assistenza ai Malati nel Corso dei Secoli* (Salcom, Varese, 1990), p. 21.
[4] G. BOTTURA, *Il Giuramento di Ippocrate. I Doveri del Medico nella Storia* (Riuniti, Rome), p. 29.
[5] Cf. D. CASERA, *op. cit*., p. 63.
[6] M. VANTI, *Gli Scritti di San Camillo* (Rome, 1952).
[7] Letter of Cardinal A. Sodano to the Superior General, Rev. Angelo Brusco, on the occasion of the establishment of the Day of Camillian Religious, Martyrs of Charity, *L'Osservatore Romano*, May 26, 1995.
[8] S. CICATELLI, *Vita di San Camillo de Lellis* (Viterbo, 1615), p. 86.
[9] A. BRUSCO, *P. Camillo Cesare Bresciani* (Il Pio Samaritano, Milan, 1972), p. 62.
[10] D. CASERA, *op. cit*., p. 89.
[11] M. VANTI, *op. cit*., pp. 52-77.
[12] A. BRUSCO (ed.), *Religiose nel Mondo della Salute* (Turin, 1993), p. 183.
[13] Cf on this subject: A. BRUSCO, *Umanità per gli Ospedali* (Salcom, Varese, 1983).
[14] A. BRUSCO, (ed.), *Religiose*, p. 184.
[15] Cf. various authors, *Coscienza Etica e Mondo della Salute* (Rome, 1991).

J. AUGUSTINE DI NOIA

The Virtues of the Good Samaritan: Health Care Ethics in the Perspective of a Renewed Moral Theology

The formulation of my assigned topic is significant: it is not just the conduct of the Good Samaritan that concerns us here but the virtues underlying that conduct.

This formulation signals a shift in prevailing conceptions of moral theology and thus of health care ethics as well. In its simplest terms, it is a shift from a precept-centered to a virtue-centered ethics. In part, this shift reflects developments in philosophical ethics and, in Catholic moral theology itself, a recovery of the riches of the biblical, patristic and high scholastic sources of tradition.[1]

But an even more important impetus for this shift has come from the renewed moral theology propounded by the Church's Magisterium in the encyclical *Veritatis Splendor* and in the *Catechism of the Catholic Church.* Catholic moral theologians and bioethicists are being invited to locate discussion of the rightness or wrongness of particular actions within the broader context of the moral good and its pursuit. In this brief paper, I shall attempt to identify the nature of this shift and indicate something of its impact on health care etichs.

In the field of health care ethics as in other areas of life, we are familiar with the question, "what must I do to act morally in this or that situation?" But the more radical question, "why be moral at all?" is one that we pose rarely if at all. Perhaps we think that the answer to this more radical question is self-evident, or that the question itself is too abstract. But it is a mistake to avoid the radical question, "why be moral at all?" By framing the issues of health care ethics precisely in terms of the *virtues* of the Good Samaritan, the organizers of this conference impel ut to take up the challenge posed by the question, "why be moral at all?" and at least to sketch how our answer here might shape our approach to the other question, "what must I do to act morally in this or that health care situation?"

The encyclical *Veritatis Splendor* is unique among the recent documents of the Magisterium in taking up the more radical question, "why be moral at all?" In adressing the question, the encyclical marks a critical turning point in the renewal of moral theology initiated by the Second Vatican Council.[2] Sweeping aside both the legalism of past Catholic moral theology and the patchy remedies for it advanced by some recent moral theories, our Holy Rather invites us to think of the moral life in a new, and perhaps even unfamiliar, way. *Veritatis Splendor* argues that, in authentic Catholic moral teaching, obedience to the moral law has its proper meaning only within the context of the divine invitation to trinitarian communion and, directed to that communion, our own transformation in the image of Christ. If not a revolution, the encyclical certainly signals a critical turning point in Catholic moral thinking—and, as we shall see, one with crucial consequences for Catholic health care ethics.[3]

The question, "What must I do to act morally in this or that situation?" is transposed in the encyclical to the plane defined by another question, "what good must I do to have eternal life?" Eternal life is nothing less than a participation in the highest Good, the good of the divine communion shared by the Father, Son and Holy Spirit. The moral life—life in Christ—involves a gradual transformation in which we become good by seeking the good.

The good we seek is thus a complex personal good. It is the good of personal union with the Father, through the Son, and in the Holy Spirit. With Christ as the pattern and principle of this transformation, moral life is a matter of growing fitness for the life of trinitarian communion, already initiated in Baptism and to be consummated in the life to come.[4]

The Catechism of the Catholic Church follows the encyclical in teaching us that moral life is nothing less than life in Christ. The Catechism's discussion of the ten commandments is prefaced and permeated by its account of the principles of the moral life which, in effect, constitutes a highly elaborated answer to the question, "why be moral at all?" Both the *Catechism* and *Veritatis Splendor* frame their answer to this question in terms of communion with the triune God and transformation in Christ. Together, they place obedience to the divine law in its properly personalistic context. Moral life as such can never be reduced to the observance of law but must be seen as the pursuit of the good that the divine law insures and undergirds.

The fault of moral theology in a more legalistic vein has been to lose sight of this profound truth of the authentic Catholic moral tradition, recovered and forcefully propounded by Veritatis Splendor and the *Catechism of the Catholic Church.*

A simple analogy will help us to see the contrast between the legalistic and personalistic conceptions of the moral life that are at issue here. Suppose that, while you are in the

process of preparing dinner, one of your children comes into the kitchen eating a fistful of cookies, and you say, "Stop eating those cookies!" When the child asks with "why, mother?" at least two replies are available to you. On the one hand, you might respond: "I am your mother, and I make the rules in this household. Here, we do not eat cookies before dinner!" On the other hand, you might say: "If you eat those cookies, you will ruin your appetite and be unable to enjoy your favorite dinner." The first answer appeals to your authority as a lawgiver and to the precepts you enjoin, while the second appeals to the good of the child. Attending only to the logic of moral argument here (and not to the principles of child-rearing!), in the first reply what is at issue is the observance or transgression of a precept, while in the second it is the embrace or rejection of a moral good.

Together, *Veritatis Splendor* and the Catechism propound a renewed moral theology in which the central categories of the moral life are not the permitted and the forbidden, but the good and the bad. The divine law forbids what is always harmful to us (viz., intrinsically evil acts) and commends what makes us good. In each action, and in some more than others, we seek the good or fail to. And through each action, and in some more than others, we become good or fail to. Virtue grows in us, or, in its absence, vice. In this perspective, our actions are right or wrong, and they incur praise or blame, because they are good or bad, and not the other way around. It is not the fulfillment of duty or of obligation as such that make us good-for then the only virtue would be obedience - but the pursuit of the moral good enjoined by duty and obligation. The moral life is a transformed or transfigured life in which the theological and moral virtues play a central role.

According to the image of Christ and through the grace of his incarnation, passion, death and resurrection, we are changed in our very being and empowered to live and act in the manner of adopted sons and daughters who share the life of the triune God. The good that we must seek and become is thus a radically personal good, that of a grace-enabled fitness for the communion of trinitarian love.[5]

We can begin to see, then, that to discuss the virtues of the Good Samaritan is to locate the central agenda of Catholic health care ethics precisely within the framework of the renewed moral theology advanced by the Magisterium.

The parable of the Good Samaritan itself encourages us to think along these lines (Luke 10:29-37). Consider a feature of the parable that is sometimes overlooked. The lawyer asks, "Who is my neighbor?" and in response. Christ tells a story.

But, by the story's end, it is clear that our Lord has in mind a question quite different from the one posed by the lawyer. Christ's question is not, "Who is my neighbor?" but, "Which of these three seems to you to have been neighbor to the man who fell into the hands of the robbers?" or, in other words, "What does it mean to be a neighbor?" To be sure, there is every reason to suppose (as the tradition has) that our Lord means us to understand that every needy person is our neighbor. But the parable itself offers a description of what it means to be a neighbor and to act in a neighborly manner towards another. The lawyer's question, "Who is my neighbor?" has a theoretical—indeed, as St. Luke suggests, a self-justifying—air about it, and invites the sort of reflection that can postpone rather than inspire action: "Is she my neighbor?" "What about that fellow over there: Is he my neighbor?" and so on. But Christ will allow none of that. "Which of these seems to have been neighbor?" he asks. In doing so, he challenges the lawyer - and us - to look, not around us at others, but at ourselves, in order to determine whether we understand and possess the personal traits that would enable us to act in a neighborly manner towards another whatever the circumstances.[6]

The Samaritan's actions in the story tell us something about his character, and thus something about the virtues that constitute neighborliness. What does it mean not only to act as a neightbor, but to be one? The Samaritan's conduct in caring for the man who fell among robbers is correct and even, as bioethicists have noted, supererogatory.[7] But the spontaneity and thoroughness of this conduct suggest something deeper. They exhibit a developed or settled disposition to act with courage, compassion and justice in situations like the one he faces in this instance. The parable thus exemplifies the principal characteristics which, according to classical moral theology, mark virtuous action: readiness to do the good, ease in accomplishing it, and satisfaction in its performance.[8]

It follows that Christ's concluding words, "Go and do likewise,"—which give this conference its theme—must be understood as a prescription not just for action but for the personal conversion and transformation that would enable us to do limewise. We must become like the Good Samaritan in order consistently to act as he did in the circumstances he encountered in the parable. It is not just his conduct that we must imitate, but his virtues.

Perhaps no passage of the Scriptures has served as a more potent source of inspiration for health care than the parable of the Good Samaritan - so much so that, as our Holy Father wrote in *Salvifici Doloris*, "it has become one of the essential elements of moral culture and universally human civilization."[9] Still, as our Holy Father also noted there, because of its specifically evangelical content, the parable makes us think of the profession of health care workers as a true vocation. It has al-

ways been clear, throughout the history of this great profession among Catholics and Christians generally, that the possibility of embracing the vocation of the Good Samaritan depends in large part upon a personal transformation."[10]

Perhaps presupposing this underlying Christian conception of the vocation of health care, modern bioethics has given it little explicit treatment and has concentrated instead on the ethics of decision-making in the particular, and admittedly difficult, situations that confront the health care professional daily. But the light of a renewed moral theology must be made to shine on bioethics.[11] Moral action in the health care field requires not just a thorough knowledge of the relevant biological and technical information and of the pertinent ethical norms, but also the interior disposition to apply them for the good of the patient as well as for the good of the professional. Indeed, as the tradition of Catholic health care has insisted, the good of the patient depends on the goodness of the professional. The virtues of fidelity to trust, compassion, prudence, justice, fortitude, temperance, integrity, and self-effacement are crucial to the formation of the dispositions necessary for a health care professional to conduct himself or herself in a manner that is consistent with the full vision of the moral life that is ingredient in the Gospel and exemplified in the conduct of the Good Samaritan.[12] Both the patient and the professional are embraced by the invitation to the destiny of ultimate communion, and ethical decisions in the health care field have their deepest meaning within the context of the pursuit of this ultimate good.

But even a brief discussions of the significance of the parable of the Good Samaritan for health care ethics would remain seriously deficient if it failed to take account of the allegorical reading of this parable, favored by many patristic and scholastic commentators and revived by some recent theologians.[13] According to this reading, the Good Samaritan is Christ, and we are like the man who fell among robbers. Construed in this way, the parable teaches us that, because of the salvation Christ accomplished for us when we were lost, the cultivation and practice of the virtues of the Good Samaritan in us depend radically on Christ's grace.

This understanding of the parable of the Good Samaritan is consistent with the renewed moral theology commended to us by Veritatis Splendor and the Catechism. It completes our endeavor to show that, in the field of health care ethics as in all areas of moral theology, we must be able to answer the question, "why be moral at all?" if we are to have a fully Christian answer to the question, "what must I do to act morally in this or that situation?" For, if the moral life is a transfigured life, then its pattern and principle is none other than the crucified, risen and glorified Christ. The freedom to embrace the good in every occasion of action and over the course of many occasions of action depends on the transformation of our nature and the conquest of our sins that are the work of Christ in us. Our participation in the ultimate good of the communion of trinitarian love depends finally on our conformation to the only Son, so that, when the Father recognizes the virtues of the Good Samaritan in us, he "will see and love in us what he sees and loves in Christ" (Preface VII, Sundays of Ordinary Time).

Rev. J.A. DI NOIA, O.P.
Executive Director of the Secretariat for Doctrine and Pastoral Practices, Editor of The Thomist, Washington, D.C. (USA)

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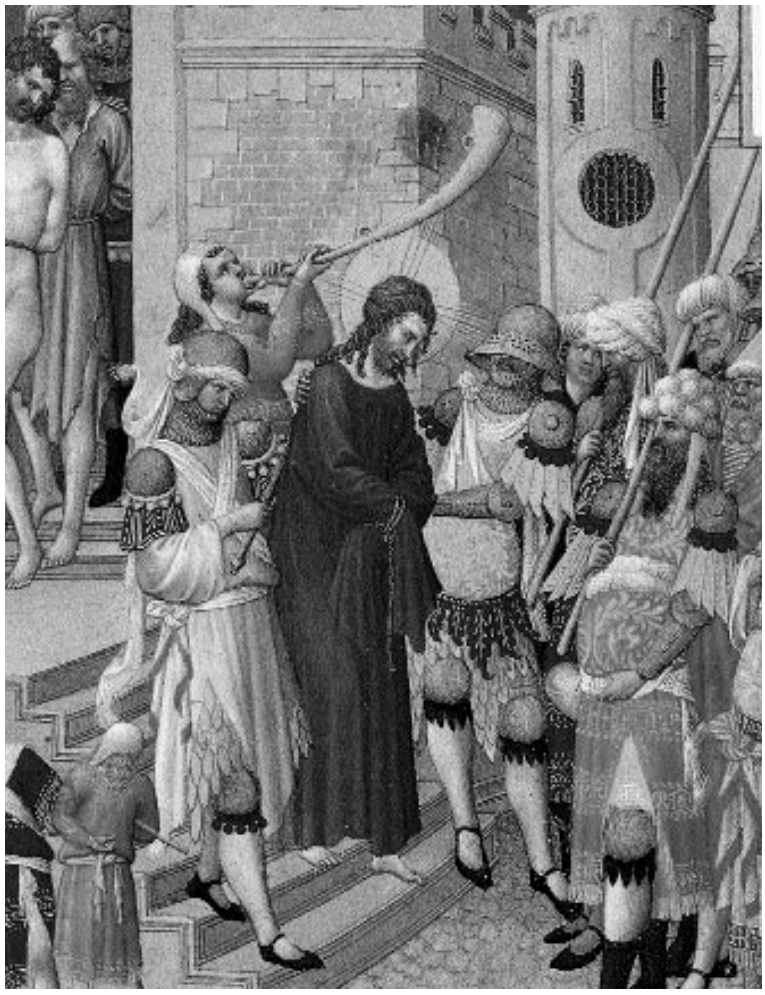


FERNANDO ANTEZANA

A Free Gift and an Act of Solidarity

The Hippocratic oath codifies a professional practice, transforming individual attitudes and virtues into obbligations that physicians and health professionals have since striven to comply with and defend, passing them on in their teaching to succeeding generations. The Hippocratic oath goes beyond professional technical commitment, since it affirms a spiritual and social responsibility before the gods and man, and before all generation, past, present and future. Imbued with ethical values, the Hippocratic oath also lays down the law.

The figure of the Good Samaritan takes up and builds on the tradition which care implies, of giving and benevolence, without asking for reciprocity. The suffering of the other, recognized and accepted by the passer-by as his own responsibility, is enough to establish personal commitment. It is a total commitment, which goes beyond the technical actions of washing, treating and bandaging wounds. Because the Good Samaritan chooses to interrupt his journey, upset his plans and the course of his life for a man who is lying wounded and sick at the side of the road.

He gives his time and money for this stranger. And the promises to *return,* which means that he takes on a responsibility in the longer term.

The figure of the Good Samaritan takes us far beyond compliance with the rule and the letter of the law. It illustrates the notion of service and willingness. In that, it sets an example for medical practice today and for the approach to health policies. With the accelerated development of techniques and the fragmentation of disciplines—the fragmentation of the human body as an object of research and intervention—the risk of depersonalizing relations between health workers and patients has increased.

The number of tasks, the workload on health personnel, institutional pressures and the need to make time pay, militate against good quality relationship. And yet, though it is too often forgotten, a good relationship with patients is an integral and decisive part of high quality, effective care.

In health and social policy, and in international cooperation itself, people too often content themselves with managing emergencies, attaching most importance to short-lived moments of compassion. There is a tendency to act on emergencies without following through, and without planning for and investing in the long term. And yet we cannot conceive of health protection and promotion as nothing more than an ambulance and first-aid service, with no support services or ongoing activities. Nor could that ever be a way to offer equitable access to health care. Here again, as the example of the Good Samaritan suggests, one must not only be there and respond to need, but also one must return to the patient, and devote time and energy to continually provoding for the patient until the task is accomplished.

If they are to succeed, disease prevention and control policies need sustained development of infrastructure, education and training of human resources, systems for the financing of care, guarantees of the quality and availability of care and drugs which must be both financially and geographically accessible.

This would mean, for example, the industrial countries—which account for about 90% of pharmaceutical research and production investment in the word—agreeing to support or undertake admittedly lengthy and expensive research on the drugs and products needed by the greatest number of people, especially in developing countries, even when profits seem marginal.

This long-term effort is what the World Health Organization has been trying to elicit from and promote among its Member States, whether they be donors or benefi-

ciaries of cooperation. We try ensure that the priorities and activities of national health or international cooperation programmes are not established and evaluated exclusively in quantitative or economic terms. WHO therefore wants to develop and promote the use of health indicators based on notions such as the social integration of people, the development of autonomy and the quality of life of each person.

These are notions that highlight the close link between respect for the dignity of individuals and peoples, irrespective of their level of income, physical capacity or economic and social productivity, and their access to health, understood as a state of personal wellbeing which goes along with their integration in society.

Science and technology are the products of human reason and are powerful instruments which should be firmly kept in the hands of hymanity in the service of human dignity and mutual respect and responsability between social groups, individuals and cultures. In this field, as His Eminence Cardinal Angelini rightly pointed out, we must be aware that no decision we make can be neutral. We must therefore help to ensure that these decision are taken in a full-informed and democratic way, with due consideration for the moral, social, political and scientific responsibilities involved. It is also an ethical responsibility for WHO which our Organization wishes to fulfil by helping to set up forums for encouraging debate and regulation, at both regional and global levels, on various aspects health policies, exchange of knowledge and technology development.

There is one further lesson—and an important one—to be drawn from the parable of the Good Samaritan. The Hippocratic oath, which sets out the rule, says that the physician must treat everyone—men and women, free men and slaves—in the same way. The Good Samaritan expresses a truth and a moral command that transcend the rule and the letter of the law.

The law says that we should treat our neighbour as we treat ourselves. However, the law in t hose days strictly defined the boundaries of the community and one's neighbour, just as it set out the relationship of duty and solidarity within the community. The Samaritan was outside that group; he was a stranger, and even the archetype of one's potential enemy. Thus, in theory, the Samaritan is typically outside the network of clan solidarity. In contrast, the priest and Levite are at the centre of the group. These men of the temple are the guardians of the law, in word and in deed. But as the parable here tells us, the example of solidarity, the word and act of truth, come from the Samaritan, the foreigner, the enemy, the outcast.

It is not the law or tradition that say who our neightbour is. The neighbour is not the beneficiary of solidarity but its originator. Whoever decides to approach the other person, to acknowledge responsability for the other person and to take care of that person, is the one who gives sense and reality to the law.

And above all, as the Good Samaritan shows, the value of moral obligation and acting on the responsibility that forms the basis of solidarity can never be limited to the members of the group to which each of us belongs by birth or by tradition. Solidarity is a universal human responsibility.

The World Health Organization has embarked on a wide-ranging review of its role and mission at global level. In order to rethink and reformulated our policies and activities for health, we must put them in the context of discussion of principles and of the ethical aims of international cooperation. WHO is called upon to provide access to health for everyone in the world, starting with the poorest, the smallest and weakest—those who are "marginalized" to use the fashionable term, or, in other words, those who are maintained outside the system by the system itself.

Promoting access for all to health, continually seeking to improve this level of health, quality of life and autonomy for everyone, such is the first calling that defines the field of competence that is the World Health Organization's. What the Hippocratic oath and the figure of the Good Samaritan teach, is that every health action is intended for other human beings, whose basic dignity must be recognized and respected.

The desire of WHO to base its new health-for-all policy on the principles of equity, respect, and solidarity, going beyond social, economic, political, and cultural boundaries, follows on from that teaching.

Dr. FERNANDO ANTEZANA
Address delivered on behalf of
Dr Hiroshi Nakajima
Director-General,
World Health Organization
by the Deputy
Director-General

Round Table

The Good Samaritans of Our Time

ENNIO APECITI

Marcello Candia: A Good Samaritan of Our Time

1. Introduction

"Can a manager be holy?" Giancarlo Galli asks in his book *L'Era dei Managers*. "The answer is obviously negative if we subscribe to the widely shared view that the manager or the entrepreneur is engaged in the acquisition of wealth and not in its distribution. It is the man who gives everything to the poor who is holy."[1] But is this really true? Is not the example of Marcello Candia evidence to the contrary? But who actually was this man?

Marcello Candia loved Alessandro Manzoni and often quoted a sentence pronounced by Cardinal Federico: "Life is not already destined to be a weight for many and a party for a few—it is a task for all, and every man will be called to account for how he has discharged that task."[2] It seems to me that this is the most suitable image by which to begin to understand this Samaritan of our times.

2. His Life

Marcia Candia was born by accident, as it were, in Portici (Naples) on July 27, 1916. His family was actually from the North of Italy and more precisely from Lacchiarella near Melagnano, in the so-called Bassa Milanese. He was born by accident, as it were, because the Candia family went to live in Naples during the First World War.[3]

His father, Camillo, was a businessman who brought up his five children (three girls and two boys, Marcello being the third eldest) to respect the values of honesty, a sense of duty and of hard work, and love for what is beautiful. He does not seem to have been a regular churchgoer but he knew how to inculcate in his children that love and respect for values which make man great. Marcello said of his father:

"From my father, who was not a practicing Catholic, I inherited a strong sense of duty and honesty and respect for freedom: the rights of the individual must never encroach upon the rights of others."[4]

His mother Luigia Mussato was a cultured and educated woman "of a very special human warmth" who "was able to give a word of comfort to everybody."[5] She was a woman of intense and deep religious sentiments and beliefs, and instilled in her children the values of faith and charity, especially towards those most in need.

In other words, Marcello Candia had two exceptional parents, or as he himself said: "I had two wonderful parents, and for this I never cease to thank the Lord."[6] As he said to Giorgio Torelli when this latter visited Brazil: "Look, I had two parents who gave me a love for life. Parents, as you know, are our closest brothers.... I remember my mother imparting the same ideas and beliefs as I had heard from the local parish priest. My mother was always on the side of the poor and she had a tender Christian love. As a boy I watched her and accompanied her on her visits of solidarity.... She went to the homes of poor people and I went with her to carry the parcels. I heard her speak to them. It was inevitable that my faith would grow in the inseparable bond with every brother. Love for God was always, always, linked to love for one's neighbor.... What else would I have done given that I carried those parcels for my mother?"[7]

Obviously enough, the roots of the vocation of Candia to charity can be found in this accompanying of his mother, and in the testimony of his mother.[8] A strong religious spirit and a passion for works of charity were expressed early on in the young Marcello: his school friends remember him engaged in prayer, in study and in the charitable works of the *Conferenze di San Vincenzo*. This organization brought him into contact with a glorious association of young Milanese Catholics—the *Associazione Giovani Studenti Santo Stanislao*.[9] This association had as a member another servant of God, Giuseppe Lazzati, a figure who was to have a major impact on the role of the lay faithful in Italian society. The Santo Stanislao association followed the impulse given to it by the blessed Cardinal Andrea Carlo Ferrari and sought to train and prepare young people for the task of giving a Christian character to society. The aim was to ensure that committed members of the Catholic laity would promote the ideals of the Gospels in the world at large.

This was certainly a period of great personal growth and development for Marcello. These were the years when the Catholic laity of Italy lived perhaps one of its happiest periods. One need only think here of a young person such as the blessed PierGiorgio Frassati and the tensions between the Fascist regime and the Catholic Church in relation to Catholic Action, a tension which culminated in that prophetic document, the encyclical *Non Abbiamo Bisogno* (1931).

These were the years when the venerable (soon the blessed) Cardinal Alfredo Ildefonso Schuster often spoke to the parish priests of his dio-

cese and gave them a criterion by which to judge the success or otherwise of their role in training and educating young people. It was a criterion based on that other great document of the Magisterium of the Church, the social encyclical *Quadragesimo Anno* (1931). The Cardinal of Milan declared:

"It is above all else in their regular visits to the poor in their homes, to the sick in hospitals, to prisoners, to those who are half frozen to death in attics in the slums of the big cities, that our good young people experience the complete fulfillment of their lives as Christians."[10] These characteristics seem to have become more pronounced in Marcello when his mother died when he was sixteen years old (7 February 1933). The suffering caused by this event brought him to a state of physical and nervous exhaustion which he was able to overcome after a year of treatment and rest through a "radical choice in favor of God," the discovery of (or a decision for) God which would lead him to declare: "Trust in, and rely upon, God who is called Compassion.... God is our father and wants to forgive us."[11]

These were very significant words in relation to the path Candia was to take if we consider that this painful experience of death left the mark of a very acute sensitivity within him, and involved great anxiety and provoked a propensity to compensatory activism. We should bear these limitations in mind in order to recognize that Marcello was not a youth or a man predestined for holiness or for great things. In him, too, there was a veritable struggle to ensure that the seeds of good which God sows in the heart of each and every human being broke the hard soil of human limits and bore fruit, as the Gospels have it, in the measure of one third, two-thirds, and to the full.

At that same time, however, when he was still very young, there was an encounter which was of fundamental importance in the spiritual journey of Marcello Candia—he came into contact with a Capuchin, Father Genesio da Gallarate. This friar "entered into souls to such an extent that they became associated with his immensely elevated spiritual experience"[12] and accompanied Candia for about thirty years, directing him towards austerity, long prayer, and the study of the saints. There gathered around Father Genesio a coterie (as we would call it today) of people from very different social, cultural and spiritual backgrounds. This group of people met twice a week in the monastery of the Capuchins in Viale Piave, that building which had seen and heard the firing of the guns of General Bava Beccaris on an unarmed crowd of workers in May 1898. There gathered around this "master of the spirit" a group which became known as "The Log" because its members used to sit beside a log-fire which was lit to produce a warm and friendly atmosphere. As one of the group was later to recall:

"Side by side could be found a clerk belonging to the old Socialist tradition and a monarchist aristocrat..., a worker of the Falk factories and a highly placed building constructor, an industrialist in chemicals (perhaps Candia?) and a Catholic writer, a famous sculptor..., and the Communist editor of *Epoca*. There was also an idealist chemist and his atheist friend."[13]

All of these people met to reflect, to discuss, and to pray. It was almost a professorial chair of non-believers a decade or two before its time. Here Marcello Candia certainly developed his ability to talk and to listen to the voices of contemporary man, his worries and his trials.

"The Log," however, was not only a place of cultural development and refinement—it also had a charitable function. The members of this group visited and helped the poor families in council houses (*case minime*) in Baggio, an area on the far outskirts of Milan.

Before meeting Father Genesio, however, Marcello had begun to spend time with another Capuchin, namely Brother Cecilio Cortinovis. This figure was a simple member of the order who spent over seventy years of his life as a porter in the Milanese monastery of Viale Piave. He had been the founder of *Opera di San Francesco*, an organization dedicated to helping the poor, and died famous for his holiness on April 10, 1984. Indeed, on April 10, 1995 the diocesan stage of the process of canonization of Brother Cortinovis was brought to a positive conclusion.[14] This friar, who bore a benevolent smile, encouraged Candia to adopt an attitude of active charity, and to express respectful and delicate love for the poor. During the cause for canonization, indeed, constant reference was made to the welcoming smile which this friar gave to the hundreds of poor people who came to the monastery—all of them were welcomed, and then said goodbye to, with a smile, with a parcel of food and with an inevitable sentence: "You know, don't you, that God loves you?."

Here we can see a very special coming into contact of holy men; a very special chain of holiness which linked together many members of the city of Milan during the first decades of this century. It is worthwhile to observe that Father Alberto Beretta, the brother of the blessed Gianna Beretta Molla, lived in this monastery before going on missionary work to help the sick and those suffering from leprosy. A fine friendship animated by a common ideal linked Father Alberto to Candia. This ideal involved serving those who were most in need. Together these two friends worked for the poor who came to Viale Piave and they also developed the idea of offering themselves for service in northeastern Brazil.

Charity, therefore, became the ideal of Marcello's life and he devoted all his energy to this ideal. In-

deed, he was convinced, as he later declared, that "the apostolate [sic] is essentially charity. When we meet a brother who is in need, we must not only speak of our faith. We must act according to our faith."[15] For this reason Marcello united constant prayer with a broad range of commitments. To one fellow member of the course he confided that every day he recited the whole of the rosary and it is well known that he went to mass every day. After mass he spent about ten minutes giving thanks, as was once the custom, and this was done with traditional prayers in the "grandfather" style as we would say today, with "I love you, my God," the "Anima Christi," and so forth.

In the meantime, and perhaps because of this strong spiritual dimension, he graduated in chemistry in 1939, in pharmacology in 1940, and in biology in 1943. Only the war and the management of his father's company (where he worked from 1939 on) prevented him from gaining a degree in medicine, which was something to which he greatly aspired.

However, Brother Cecilio did not communicate only the spirit of charity to Marcello. In the monastery of the Capuchins in Viale Piave in Milan reverence was paid to the memory of Father Daniele da Samarate, a missionary in Amazonia (Tacunduba) who died of leprosy in 1924, a disease he had caught while in the service of the lepers. In many respects Father Daniele was like the blessed Father Damiano, a Belgian. In the summer of 1937 the father sent Marcio and his brother Riccardo to Brazil to "see the world." Marcello was "magnetized" by the poverty of the *favelas* of Rio de Janeiro and by the heroic dedication of the missionaries and nuns.[16] The feeling that he had a missionary vocation is, indeed, to be traced to this visit.

After the end of the Second World War Marcello took over the management of his father's company. His father died on April 27, 1950. Marcello displayed excellent managerial skills and the *Fabbrica Italiana di Acido Carbonico Dottor Candia* rose to occupy a high position on the European horizon.

In 1946 Marcello Candia met Monsignor Aristide Pirovano del Pile who was about to leave for Brazil to found the Macap mission[17] on the Amazon river where he would subsequently become the first bishop of that area. Monsignor Pirovano would always remain linked to Marcello Candia and was later to say of him:

"What always struck about Marcello was his life of prayer. He was very active, never stopped working, planning, or trying to convince other people. He was an engine which was constantly running. But all this activism was imbued by a union with God, a constant prayer which was his

life. He thought only of God, of the poor, of works of charity. I do not know if he actually had other thoughts. He was in love with God and the suffering humanity which the Lord had led him to meet."[18]

Over the course of the years Candia's missionary work took practical form and spread. He founded the *Associazione Laici in Aiuto alle Missioni*, the first organization in Italy to be concerned with lay missionaries. He established the review *La missione* in order to promote the culture of missionary work. He organized the *Centro di Assistenza Missionari Reduci*, which was the medical school for missionaries at the University of Milan. He became secretary of the SILM (*Secretariat Internationale du Laicat Missionaire*) and of the UCCI (*Union Catholique de Cooperation Internationale*). With the then Archbishop Giovanni Battista Montini he created the *Collegio Internazionale per gli Studenti di Oltremare* to help foreign students in Italy, and the *Segretariato di Cooperazione Missionaria* to establish links between the various lay missionary movements in Italy. The *Collegio Internazionale per gli Studenti d'Oltremare* should be remembered because it gave rise to the hospital at Macap, as indeed Candia later made clear:

"The idea was not mine. It belonged to the then Archbishop of Milan, Monsignor Montini, with whom I had set up a college in Milan for young people from the third world who wanted to earn a degree in medicine. However we discovered that the project had a defect—the young people wanted to remain in Europe and did not go back to their countries. It was for this reason that a hospital in the equatorial jungle was created with the aim of bring Christian witness to everybody, and to poor people as well."[19]

On the night of October 22-23, 1955, when Candia was already thinking of selling the company and going to Amazonia, an explosion (for which Candia bore no responsibility at all) destroyed the factory. Candia was not discouraged but rebuilt everything, without, however, reducing his commitment to missionary work.[20] Indeed amidst the rubble of the factory he declared: "First of all...I must provide work for everybody."[21]

On the other hand, he was convinced that "my workmen are my land of missionary work." Marcello Candia faced up to this moment with that courage which springs from faith,[22] and with the same decisiveness—but also with the same internal wounding—as Job.[23] A year after the disaster he wrote to Monsignor Aristide Pirovano and confided: "I think that one of the elements in preparing oneself for a life of charity is the acceptance with simplicity and sincerity of the will of God.... [Coming to you] is my greatest wish and I hope above all that this is the will of the Lord."[24]

In addition to the reconstruction of the factory other buildings sprang into being. At Macap on January 25, 1961 the first stone was laid of the Hospital of St. Camillus and St.

Louis. This hospital had been planned for a long time by Candia and Monsignor Pirovano, and Marcello wanted to go there as soon as possible. Indeed he was convinced, as he declared one day to his sister, that "it is not enough to give economic help, we must share in the lives of the poor, or at least as far as this is possible."[25] This would be the leitmotiv of his long stay in Brazil. Each time that he returned from a journey to the interior he would reflect upon the poverty he had seen there and would observe: "If we are really Christians we must share what we have."[26]

Thus it was that on June 7, 1965 he sold his interests (three companies in Milan, Naples, and Pavia) and put his family's business affairs in order. He then moved once and for all to Amazonia. He was forty-nine years old and he was alone. A few months earlier (in April 1965) Pirovano had been called back to Italy as superior general of Pime. This was when the virtue of Candia emerged in a very special fashion. As he said to a female friend and helper: "Before becoming involved in the undertaking he suddenly lost a friend, the superior, the guide who had provided him with protection and help. I remember that he said to me at that time: `I now place myself completely in the hands of God.'"[27]

Candia, who never learnt to speak Portuguese perfectly and always suffered at the hands of the local climate, took his managerial skills to Brazil. As Candia himself said, "The effectiveness of works of charity is a form of prayer."[28] The program he was to implement had been dictated (or advised) by his long-standing Archbishop, Giovanni Battista Montini, to whom he was always linked by sincere—and mutual—devotion. The future Pope said to him:

"If you go to Brazil and build a hospital, make it Brazilian. Make sure to avoid all forms of paternalism, do not impose your ideas on others, even where your intentions are of the best. Create a hospital not only for the Brazilians but with the Brazilians, and make it your ultimate aim to no longer be necessary. When the moment comes when you feel useless because the hospital can go on without you, at that moment you will have achieved a real work of human solidarity."[29] Candia was loyal to this mandate. He finished the construction of the hospital of Macap (1967) and the hospital was later placed in the hands of the Camillians (1978).

The experience of his encounter with lepers was, however, of crucial importance in his journey along the path of charity. To describe that event we need go no further than the words he himself used in a letter written in 1977. We are here in the leper colony of Marituba which was then popularly known as the antechamber to Hell:

"I spoke to many lepers. Unfortunately with some of them the conversation stopped almost immediately, and this made me immensely sad. The whole of the morning went by in this way. At about midday, because of tiredness, fasting and a little heart trouble, I sat at the feet of a tall mango tree to get my breath back. I was immediately called from my thoughts by the voice of a woman who kindly inquired as to whether I felt well. The brotherly impression provoked in me by that voice was in contrast with the deformed face of the woman who seemed more than forty years old but in reality—as I learned after successive visits—was only nineteen. She had been in the leper colony for ten years and had never received a visit. She immediately returned with a glass of water and I felt the authentic joy, as had often happened many times in my life, of receiving more than I had sought to give. To my question as to how I could help her, I heard her reply that for a long time she had been waiting for a sewing machine. Thereafter an atmosphere arose in relation to the lepers which was one of simple and cordial friendship, which was perhaps the thing they aspired to the most.... We must see the leper not only as a person who has to be helped but as a richness within the Mystical Body of Christ. This is because the leper, too, has things to give."[30]

In order to demonstrate the shared affinity between Candia and his brother lepers we can cite the reply of perhaps the most popular of the Hansenians of Marituba, Lucio Paracauary Calado, known as Adahlucio: "Ask? Ask (why there is leprosy?).... I neither ask why nor how because I have always had faith. For me it is enough to believe. I repeat this sentence: I will believe in you for ever, Lord."[31]

Marcello's activity was ceaseless. He built the City of Milan Social Center (1966) in the leper colony of Marituba (Belem) and placed it in the hands of the missionaries of Pime. This became a model leper colony, and it is no accident that when John Paul II expressed a wish to visit a leper colony during his apostolic pilgrimage to Brazil in July 1980,[32] he was taken to this center. Perhaps the most beautiful testimony of that visit was given by a blind Hansenian. This man was radiant with joy at having "seen the Pope." A nun, sister Celestina Magni, smiled and asked him how he could have seen the Pope given that he was blind. The Hansenian replied: "Sister, one can also see from within; one can also see with the heart!"[33] These are touching words—the miracle of love of Marcello Candia, his missionaries and his nuns had transformed the antechamber of Hell into a place in which the blind could see (cf. *Mt* 11:5): Marituba, therefore, was a House of the Gospels.

Care and concern for spiritual life was no less important. The Little Carmel of St. Thérèse of the Child Jesus in Macap (1977) and *Belo Horizonte* (inaugurated after his death in 1984) thus came into exis-

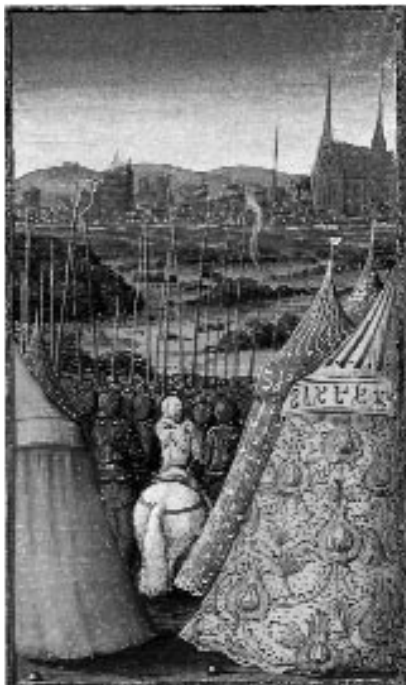
tence. In relation to such initiatives, in the same letter which has already been cited Candia wrote, "Only a word of faith and love for Christ, testified to in the leper colony by the presence of a religious community, could create within them a hope for life and make them aware of their value in the Community of the People of God."[34] In this sense, it is no accident that the bell of the Carmel in Macap, which was donated by Giuseppe Lazzati, has inscribed on it: "Voice of love that solicits loving."[35]

Candia also took part in the support and development of very many other works of charity: the Santana Hospitality House (in the port of Macap), the leper colonies of Prata and Porto Velho, the hospitals of Gaja and Balsas (State of Marahnao), the *Favela do Borel* in Rio de Janeiro, the social centers in Caloene and La Cruz Liriada, the Base Community in Rio Branco, and the Camillian seminary in Macap. This list brings to mind the testimony of Monsignor Luigi Giussani: "One of his characteristics was that all the good that he found on his path was one good, a special call for him.... He was really ecumenical. He had neither boundaries nor barriers. He was always ready to do anything as long as there was good to be done."[36] In all his works Candia always paid especial attention to the spiritual aspects of things and sought to give not only medical help and charitable support, but also spiritual sustenance, to all those—and they numbered millions—who turned to him. We can understand the spirit which animated him from one of the interviews that he gave:

"What I think is most important in our work—that of myself and my helpers—is the personal relationship that we have with the people who need us. The hospital that we have built, the equipment, and the work of the doctors and surgeons is not so important as making them understand that we do not work for the lepers but with them—that is, with fraternal love and human solidarity. If this spirit were not present, what would be the value or use of all these facilities, the funds, and all the rest? It is for this reason that I always say to myself that we need a religious spirit if we want to serve the poor well, that is to say a spiritual motive, a motive rooted in faith.... I myself have seen that in serving the poor, forming friendships with the poor, I have found my treasure: I have received, as the Gospels have it, my hundred for one."[37]

And he went on:

"The absolute priority is the spiritual priority: the technical and economic instruments are important and we should use them, but they are worth nothing if they are not accompanied by friendship, by attention being paid to the individual, and by help from God."[38]



Not everything is easy, but difficulties are also a means and an instrument by which to grow. Thus it was that one day he had the courage to recognize his weaknesses and fragility. He confided as follows to Piero Gheddo: "A crisis befell me at times when I touched in tangible form the difference between what we actually did and what we might have been able to do. I see that working all day and at times also the whole of the night, I and those who work with me are always merely a drop of water in the river of human suffering which surrounds us. Here at Macap the branch of the Amazon river which flows in front of us and then flows into the ocean is twenty-two kilometers wide, and at times I sit upon the banks of this majestic river and think to myself: everything that you do, Marcello, is just a drop in the Rio.... At times this throws me into a state of crisis, but it is a crisis which has a good effect because I always remember that we humans are small and that God is great!"[39]

These words remind us of those written by Pope John Paul II in the encyclical *Redemptoris Missio*:

"The missionary is the man of the beatitudes.... In a world troubled and oppressed by so many problems, which generate pessimism, the proclaimer of the "Good News" must be a man who has found true hope in Christ."[40]

At the outset, naturally enough, Candia was surrounded by suspicion. Doctor Macedo, the president of the Institute of Social Security of Macap, admitted that he did not want to sign the requests of the hospital because he believed that Candia was mad: "Who is this madman who has come to build a hospital in Amazonia?"[41] Candia was also subsequently investigated for "having brought medicines into Brazil illegally."[42]

But with the passing of time the honesty of his intentions was recognized and the Brazilian government itself gave Dr. Candia the honor of the *Cruzeiro do Sul*, the first time such an honor had been conferred upon a foreigner and the most important honor for services rendered to the nation that exists in Brazil. In 1975 the review *O Manchete*, the most widely read weekly publication of the country, proclaimed him "the best man in Brazil." Equally prestigious forms of recognition were accorded him in Italy: the Angelo Motta or "Goodness" Prize in 1970, the City of Florence Prize in 1976, and the Feltrinelli Prize in 1982. This was conferred on him by the then President of the Republic, Sandro Pertini, "for an exceptional undertaking of high moral and humanitarian value."

Candia suffered from a bad heart, and from 1967 to 1977 he had five heart attacks and was forced to undergo an operation for a triple bypass. But it was not his heart which surrendered. In August 1982 he was diagnosed as having cancer of the liver, and in this way the great trial of Candia begun. In addition to the physical suffering he had to endure

there was also the disappointment caused by some of those to whom he had entrusted his work—there were false accusations that money had been stolen from the lepers. However, he did not cease to struggle and when he felt the end draw near he decided to return to Italy to settle the question of the Dr. Marcello Candia Foundation, which was to continue his work. He died in Milan on August 31, 1983, leaving himself with trust in the hands of God. A few days before dying he said to a friend of his: "If the Lord wants my work to go on, it will go on. Now he calls me and I am ready to turn out the light."[43]

The words he exchanged with his parish priest and spiritual director Don Peppino Orsini were even more significant, and they were as follows:

"Death does not frighten me because it is a passage from a God who is Father and little understood to a God who is Father seen face to face.... Yes, indeed, the highest act of love which Jesus has manifested to me is to have placed me in suffering, giving me thereby the opportunity to give myself to him with all my joy and with all my love.

Jesus today has made me live the most beautiful experience of my life and has made me understand that it is not enough to work for the Kingdom of God; it is not enough to pray to the Lord. Of greater importance is the acceptance with humility and readiness of pain how and when God allows it.... This is really very beautiful. Only in suffering can we achieve an understanding of the love of God."[44]

Cardinal Carlo Maria Martini of Milan celebrated the funeral rites, and, among other things, he had this to say:

"I still have in mind, in this very moment, his face of only three days ago held by intense pain but bearing luminosity in his eyes and with the murmuring of prayers on his lips which expressed his intimate union with the suffering of Jesus for his Church. And it was in that moment, in that brief conversation with him, that there appeared the most lively sign of the authenticity of his entire mission: commitment, effort, enthusiasm, organization, attention to all needs, an ability to bring forth energies..., but all this was lived with detachment, with humility, with an adherence to the profound will of God, and these elements, in the moment of extreme suffering, revealed their incandescent authenticity"[45]. The Archbishop emeritus of Milan, Cardinal Giovanni Colombo, echoed these views in a homily on the thirtieth day after Candia's death (September 30, 1983):

"Although Manzoni was not a saint, like Candia..., to Candia the Milanese could offer a place...at the top of the dome all to himself so that with the golden Madonna he also

could participate in the senate of our saints who intercede not only for the People of God but also for the whole city."[46]

The fame of holiness of Marcello Candia was such that there were immediate requests for the introduction of the process of canonization, and this was officially initiated by Cardinal Martini in the Church of the Holy Guardian Angels of the parish of Candia on 12 January 1991 and concluded at the same place on February 8, 1994.

3. How Should We Take Our Leave of Him?

What was the secret of this man? I believe that it can be understood from some of the answers that he himself gave. The first is that given to Piero Gheddo who once asked him about the reasons for his untiring activity. Candia replied:

"I consider my vocation as a service, by a layman, to the Church, to missions and to the poor. A service which is not limited in time or in extension. Now, since we must always stay young I believe that the best way to do so is to always answer the calls of the Lord. For this reason, in everything that the Lord makes me meet on my path and inspires me to help I give myself to the utmost."[47] The second answer which Candia gave, which was almost complementary to the first, demonstrates the primary importance of contemplation:

"My 'secret' is available to everybody and is not even a secret.... The only thing which matters is union with God in every form that it takes: prayer, meditation, reflection. For me the moment of union with God constitutes the essential source of energy for everything else. First prayer and then any form of apostolic activity. This is the fundamental force for any proclamation of the truth and witness to love."[48]

I believe that we can thereby understand why the prayer which inspired Marcello Candia during his life was that favored by a man who was very similar to him—Raoul Follereau. It is an anonymous prayer of the fourteenth century:

> Christ does not have hands;
> he only has our hands
> to do his work today.
> Christ does not have feet;
> he has only our feet
> to guide men
> along his road.
> Christ does not have lips;
> he has only our lips
> to speak to the men of today.
>
> Christ does not have means;
> he has only our help
> to lead men to him.
> We are the real bible
> which men still read!
> We are the last message of God
> written in works and words.

Candia himself added his own comment:

"Profoundly convinced by the truth and the contemporary relevance

of this message, which is so stimulating, I have decided to continue my journey until the end, at the service of all my sick and needy brethren, with a special predilection for the Hansenians."[49]

But perhaps an observation made during a conversation with a nun who had pointed out that he was not obliged to be poor is more revealing. Candia replied to her: "But I, with my baptism, have made a pact with Christ."[50] And this is the pact of someone who shares the awareness of Peter: "Lord, to whom should we go? Your words are the words of eternal life" (*Jn* 6:68) And now, to conclude this paper, I would like to make my own the words of his sincere friend: "One must and can only thank the Lord for the present which he made us, placing him on our path to make us uneasy."[51]

Rev. ENNIO APECITI
Professor of Church History
at the Seminary of Venegono, Italy

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PIERO GHEDDO, *Marcello Candia. Un Manager a Servizio dei più Poveri*, (Paoline, Milan, 1994).

Notes

[1] EUGENIO FORNASARI, *"Marcello Candia: Manager e Santo,"* in Vita Pastorale, 2/1993, p. 96.

[2] ALESSANDRO MANZONI, *I Promessi Sposi*, chapter 22.

[3] Marcello Candia's father had moved to Naples in 1915 to enlarge the second factory of his Burgeoning company, *La Fabbrica italiana di Acido Carbonico Dottor Candia e C.* It was therefore in Naples that Marcello (1916) and his sister Emilia (1918) were born. However, the youngest brother, Riccardo, was born in Milan in 1922. 4. PIERO GHEDDO, *Marcello Candia. Un Manager a Servizio dei più Poveri*, (Paoline, Milan, 1994), p. 15.

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

[6] *Ibid.*, p. 10.

[7] GIORGIO TORELLI, *Da Ricco che era. La Frontiera del Dottor Candia sul Rio delle Amazzoni*, (Editoriale Nuova, Milan, 1985), pp. 35-36.

[8] This emerges from the subject: Piero Gheddo, *Marcello Candia. Un Manager a Servizio dei più Poveri*, (Paoline, Milan, 1994), p. 57.

[9] MARIA CRISTINA FORESIO DAPRA, *La Santo Stanislao di Milano. Un'Esperienza Studentesca del Cattolicesmo Ambrosiano*, (NED, Milan, 1983). Id., "Santo Stanislao, Associazione," in *Dizionario della Chiesa Ambrosiana*, 5, (NED, Milan, 1992), pp. 3212-3215.

[10] ALFREDO ILDEFONSO SCHUSTER, *Memoriale ad Parochos. Lettera Pastorale al Ven. Clero per la Quaresima dell'Anno MCMXXXIX*, (SEI, Turin, 1939), p. 34.

[11] PIERO GHEDDO, "Perché la Sanità Scuote le Coscienze," in *Mondo e Missione*, 112, 1983, p. 607.

[12] PIERO GHEDDO, *Marcello dei Lebbrosi*, (De Agostini, Novara, 1990), p. 28.

[13] *Ibid.*, p. 30. 14. The description of this holy friar offered by Teresita Schenoni should be cited here. TERESITA SCHENONI *"Il Tempo non Conta, se ci Lascia un Santo,"* in L'Avvenire, May 6, 1984: "His life was spent in the service of God, beyond all the frontiers of selfishness.... Only now is it possible to discern the gigantic stature of this most simple, most innocent, most hard-working, strong as an oak tree, smiling as he knew how to smile, friar. He spent his long days paying no heed to tiredness, calm before the at times cruel events which reality

presented to his gaze. And his answer was always the same: give, give love with infinite patience and understanding so that God's creatures would not fall into temptation, so that they would refind that peace which had been lost along the dark paths of life. Not one of those over the long years who approached Brother Cecilio ever went away without experiencing a mysterious consolation. This was his secret, a secret that the Lord had entrusted to him for the illumination of his mission and to fill his days with that certainty of the divine which belongs to saints!" We who chaired the commission of diocesan inquiry for the cause of canonization of this friar share this judgement.

[15] PIERO GHEDDO, *Marcello dei Lebbrosi* (Novara, 1990), p. 113.

[16] Cf. *ibid*., pp. 47-48.

[17] RUGGERO ALCINO, *"La Prelazia di Macap, l'Ambiente, il Pime,"* in *Quaderni di Infor-Pime*, no. 11, Rome, 1978.

[18] PIERO GHEDDO, *Marcello dei Lebbrosi* (De Agostini, Novara, 1990), p. 15.

[19] Taken from Piero Gheddo, *Marcello Candia. Un Manager a Servizio dei più Poveri* (Paoline, Milan, 1994), p. 92.

[20] As Monsignor Aristide Pirovano makes clear: "He wrote a letter to me in Macap in which he really appeared as a modern Job engaged in a titanic struggle to rebuild and pay off debts in order to realize the dream of his life and become a missionary in Brazil. I am convinced that the Evil One sought to destroy this man and deprive him of the opportunity of fulfilling his dream. But Marcello was very stubborn and had the faith which moves mountains." (Piero Gheddo, *Marcello Candia. Un Manager a Servizio dei più Poveri*, Paoline, Milan, 1994, p. 73).

[21] PIERO GHEDDO, *Marcello dei Lebbrosi* (De Agostini, Novara, 1990), p. 125.

[22] PIERO GHEDDO, *Marcello Candia.Un Manager a Servizio dei pi Poveri* (Paoline, Milan, 1994), p. 34.

[23] He welcomed Monsignor Pirovano, who had come to visit the ruins of the factory with a quotation from Job: "The Lord has given, the Lord has taken away, blessed be the name of the Lord," (PIERO GHEDDO, *Marcello dei Lebbrosi*, De Agostini, Novara, 1990, p. 125).

[24] PIERO GHEDDO, *Marcello Candia. Un Manager a Servizio dei più Poveri* (Paoline, Milan, 1994), p. 75.

[25] *Ibid*., 82.

[26] PIERO GHEDDO, *Marcello dei Lebbrosi* (De Agostini, Novara, 1990), p. 162.

[27] PIERO GHEDDO, *Marcello Candia. Un Manager a Servizio dei più Poveri*, (Paoline, Milan, 1994), p. 69.

[28] *Ibid*., p. 90.

[29] *Ibid*., p. 93.

[30] From the letter for his *"Missionary Spiritual Community,"* dated February 27, 1977. Taken from "La Testimonianza di Marcello Candia," in Mondo e Missione, 112, 1983, p. 585.

[31] GIORGIO TORELLI, *Da Ricco che era. La Frontiera del Dottor Candia sul Rio delle Amazzoni* (Editoriale Nuova, Milan, 1985), pp. 82-83.

[32] The visit took place on July 8, 1980.

[33] Taken from PIERO GHEDDO, *Marcello Candia. Un Manager a Servizio dei più Poveri* (Paoline, Milan, 1994), p. 111.

[34] *Ibid*.

[35] Taken from PIERO GHEDDO, *Marcello dei Lebbrosi* (De Agostini, Novara, 1990), p. 205.

[36] *Ibid*., p. 141.

[37] Taken from *"La Testimonianza di Marcello Candia,"* in Mondo e Missione, 112, 1983, p. 586.

[38] PIERO GHEDDO, *Marcello Candia. Un Manager a Servizio dei più Poveri* (Paoline, Milan, 1994), p. 115.

[39] PIERO GHEDDO, *"Perché la Santità Scuote le Coscienze,"* in Mondo e Missione, 112, 1983, p. 611.

[40] JOHN PAUL II, Encyclical *Redemptoris Missio*, December 7, 1990, no. 91.

[41] PIERO GHEDDO, *Marcello Candia. Un Manager a Servizio dei piò Poveri* (Paoline, Milan, 1994), p. 87.

[42] *Ibid*., p. 97.

[43] *Ibid*., p. 145.

[44] *Ibid*., p. 147.

[45] *The Archbishop at the funeral.* Mondo e Missione, 112, 1983, p. 630.

[46] Taken from *"Gli Amici ne Parlano,"* in Mondo e Missione, 112, 1983, p. 619.

[47] *Ibid*., p. 155.

[48] PIERO GHEDDO, *Marcello dei Lebbrosi* (De Agostini, Novara, 1990), p. 301. See also: GIORGIO TORELLI, *Da Ricco che era. La Frontiera del dottor Candia sul Rio delle Amazzoni* (Editoriale Nuova, Milan, 1985), p. 49.

[49] *Ibid*., p. 227.

[50] *Ibid*., p. 214.

[51] Taken from Eugenio Fornasari, *"Marcello Candia Manager e Santo,"* in Vita Pastorale, 2/1993, p. 99.

RICHARD BRULLMANN

Albert Schweitzer: A Good Samaritan of Our Time

During a mission meeting Albert Schweitzer discussed passages from the bible with a number of African students. When he came to the parable of the Good Samaritan, Schweitzer used the words of Jesus to ask them: "who was a neighbor to the man who had been attacked by thieves?." The answer he received was spontaneous: "You, Doctor!" Who was this man who was the subject of such an answer? In Alsace, at the gates of the medieval town of Kaysersberg, there is a house with a bell tower which is used as a community center by the Evangelical Church. On one side of the entrance there is an inscription: "Birthplace of Dr. Albert Schweitzer—January 14, 1875."

But the real homeland of Albert Schweitzer is Gunsbach in the Munich valley. It was here, six months after the birth of the child, that Albert Schweitzer's father was made pastor. It was here that Albert spent a happy adolescence free from worries. But this was a period of his life which was by no means a source of pleasure. This was because Albert noticed that everything went well for him and he was thus especially sensitive to the suffering of other people, whether they were near or faraway. He had begun to see how animals suffer at the hands of men.

For this reason he became above all else the Good Samaritan of animals. Two pieces of writing by Albert Schweitzer well bear this out:

"I was unable to understand—and this was before I started my school days—why evening prayers involved calling for the well-being of human beings alone. Thus it was that after my mother left me after giving me a kiss and an affectionate "good night," I quietly uttered another prayer: Good Lord, protect and bless everything that breathes; defend all living things from evil and let them sleep in peace!"

The second piece was as follows:

"I was perhaps seven or eight years old when something happened which left a deep impression on me. Together with Henri Braesch I made some catapults. One Spring morning, an Easter Sunday, Henri said to me: "Come on, let's go into the vineyards and go for the birds!" Even though the idea horrified me I did not dare to say no out of a fear that I would be teased. We went up to a tree which was still bare but which was full of birds. They were unafraid of us and sang happily on that clear morning. Going forward in bent fashion like an Indian on a hunt, Braesch held the stone and pulled the band of the catapult. Obeying his powerful look, I did the same. My conscience tortured me but I promised myself that I would not aim properly. At that moment the church bells began to toll and their harmonies mixed with the chorus of the birds in that radiant sky.

It was the first ringing of the bells before the main ringing which took place on the half hour. For me it was if heaven was speaking. I threw down my catapult, scared the birds so as to drive them away from the dangers of Braesch's weapon, and ran as fast as I could to my home. Every time that I hear the bells of Easter ringing in the Spring sky, with the trees stretching forth their naked branches, I experience the emotional remembrance of a commandment which the strict voice of those bells once brought to my mind: "Thou Shalt not Kill!"

Schweitzer soon became the Good Samaritan of men.

As a student, in order to protect a Jewish wandering salesman from the mocking and teasing of children, he used to accompany that person through the streets of the village.

Albert Schweitzer was concerned with the question of the coexistence of the two principal currents of Christianity even before there was talk of ecumenicalism, and this was certainly a part of his work and mission. In discussing his childhood he wrote as follows: "My child's heart was happy at the fact that in our village both Catholics and Protestants held their services in the same church...I would like all the churches of Alsace which are in the hands of both denominations to remain as such, as future testimony to that religious concord to which our hopes should be directed if, indeed, we want to be real Christians." As Schweitzer's family was melomaniac, Albert began to study piano at the age of five. At the age of eight he went on to the organ. Eugene Munch gave him a real and authentic training in the organ, and it was thanks to Munch that Albert came to know the music of Johannes Sebastian Bach.

But it was the organist and composer Charles-Marie Widor who exercised the greatest influence on the musical activity and experience of Schweitzer. At a very early age Albert Schweitzer came to be recognized at a world level as being an organist of great talent. It was also Widor who directed Schweitzer towards the music of Bach and it was thanks to this teacher that Albert wrote first in French and then in German an introduction to the music of Bach—a work which remains today an important point of reference.

For Schweitzer music was not only a pleasure or a means to personal fulfillment. His organ concerts

enabled him to raise the funds necessary to allow him to continue with his studies and later meant that he could provide financial support for his hospital in Labaréné.

At the age of eighteen Albert Schweitzer began his undergraduate studies in theology and philosophy at the University of Strasbourg. In 1898 he passed his first theology exam and in 1899 he went to Paris and Berlin where he stayed for significant periods of time. He then was awarded a doctorate after presenting a thesis on the religious philosophy of Kant. In the same year he was made preacher at the church of St. Nicholas in Strasburg.

In addition to all this he also dedicated himself to the study of the New Testament. On the 2 July 1900 he was awarded a degree in theology with a study on the Last Supper and in 1902 he became professor at the Faculty of Theology at the University of Strasburg after presenting a study on the "Mystery of Messianism and the Passion of Christ."

In his new capacity as a university professor, he dedicated himself essentially to Jesus and to Paul. His research led him to publish two works: "A History of Research on the Life of Jesus" and "A History of Research on St.Paul."

In this way he came to be convinced that the Christian faith—if it really wants to deserve the name—must express itself at a practical level as a principle of life. And the implementation of this principle would indeed determine and shape the rest of Schweitzer's life. In October 1905 Albert Schweitzer surprised both his parents and his friends by telling them about his plans to begin the study of medicine in the autumn, with the idea of then working as a doctor in equatorial Africa. Indeed, for some time he had had this plan in mind and he now began to put it into practice. His gratitude for the happiness which had been given him from the time of his university studies led him to live for art and science until the age of thirty and then to dedicate himself entirely to those who were less happy than himself.

At that moment he did not know how things would really turn out in practice. But in the autumn of 1904 Schweitzer found in his office a statement by the Society of Missions of Paris which asked for people to help with mission work in Gabon. He realized at that moment what it was that he had to do.

This decision amounted to a "Yes" to Christ's call to follow Him. Schweitzer wrote as follows:

"I increasingly realized that I did not have the right to accept the happiness of my youth, of my health, and of my ability to work, as being free gifts. A deep awareness of my privileges enabled me to understand with increasing clarity that parable of Jesus which declares that we do not have the right to lead our lives

for our own advantage. The person whose life is full of blessings and benefits must in turn give such things in equal measure. The person who is spared suffering must help to reduce the suffering of others. All of us must bear a part of the burden of pain which afflicts the world."

As a result of special permission given to him by the government, in the years to follow Schweitzer was both a teacher and a student at his university. Whilst teaching theology he also studied medicine. At the same time, however, he continued to be a pastor at the church of St. Nicholas.

In October 1911 he passed his medicine exam. He had earned the money to prepare this exam at the French music festival of Munich where he had performed the "Holy Symphony" of Widor under the direction of the composer himself. He spent the spring of 1912 in studying tropical medicine. At the same time he began his medical thesis on the subject of the "psychiatric analysis of Jesus."

In preparing for his departure for Africa his wife—whom he had married on 18 June 1912—proved to be of the greatest help. Thanks to donations from his friends and money raised from his organ concerts, Schweitzer managed to raise enough money to establish a small hospital. When everything was ready he suggested to the Society of Missions of Paris that he become the medical doctor of the Lambéréne mission, and offered to pay for the expenses of the medical part of that mission.

In this way his work as a Good Samaritan begun in practical form.

On 26 March 1913 Albert Schweitzer and his wife left Bordeaux for Africa. On 18 April they arrived at Lambéréne where they were welcomed with open arms by the missionaries.

Lambéréne is in the Republic of Gabon, and is about forty kilometers south of the equator, situated on the banks of the river Ogoué. Schweitzer would soon have to treat about forty sick people every day. The doctor was helped by his wife, who had been trained as a nurse. The First World War brought a rapid and abrupt end to this promising and hopeful activity. Because Alsace at that time was a part of Germany, Albert Schweitzer was seen as an enemy by the French colony of Gabon. At the outset he was allowed to continue his activity, but under strict control. Later on, however, he was prohibited from going on with his work. These unexpected moments of freedom enabled Schweitzer to reflect upon a question which had already occupied his thoughts. The war brought out in brutal fashion the decadence of civilization. The acceptance of inhuman behavior which the war involved demonstrated that men had stopped thinking about good individual behavior and the construction of a truly humanitarian society.

Fully aware of the uselessness of going on deploring the decadence of civilization, Albert Schweitzer strove to find new ways of renewing that civilization. In this way he came to understand that the future would be strictly linked to the way life was

thought about. Only that person who was able to say "yes" to life and to the world in which he lived would be able to promote civilization. A positive attitude towards life and the world involved an ethical sense—that is to say responsible and honest behavior on the part of man.

For months Albert Schweitzer sought the answer to the question of how men could live in harmony with each other and with the world. At dusk of the third day of a long journey on the Ogoué in September 1915, the answer suddenly appeared to him: "respect for life."

The person who thinks about the world and about himself sees that everything which surrounds him—whether plants, animals or his fellow men—cling to life just as he himself does. The person who understands this must treat everyone and everything with respect.

God has given life to every being so that it carry out the task which it has been assigned. In order to respect God it is necessary to help each being to attain fulfillment—such is the good behavior which was originally envisaged for man. The person who behaves in this way, behaves well.

It is more than evident that the ethic of respecting life becomes effective only when we manage to turn it from being a mere idea into actual every day practice. Albert Schweitzer did not limit himself to behaving like this—he constantly reminded us of our duties in similar vein. Our generation has before it the great question of the defence of the environment and more than previous generations it is able to understand how topical this need really is.

Albert Schweitzer, of course, realized that this basic principle was in contradiction with actual reality. In nature a being lives at the expense of another being, and even man himself cannot keep himself alive without taking the lives of plants and of animals. But the person who feels himself touched by this great need understands his responsibilities. He no longer has a prejudicial approach to the life of other people because of neglect or for reasons of personal advantage. On the contrary, he strives in all situations to act with discernment and to apply his conscience. The more a man builds his daily life upon such bases, the more is he able to give a meaning to his own life and to that of the people who surround him. At each moment he must employ his conscience to the utmost to decide what he must do in order to do what is good.

For Albert Schweitzer it was evident that respect for life is in the end nothing else but the message which we encounter in Jesus. For this reason he wrote that:

"The ethic of respect for life refers to everything which includes ideas of loving, of devotion, of the sharing of suffering, of the sharing of joys, and commitment to good." Or in more simple terms: "The ethic of respect for life is an extension of the ethics of love. It is the essential thought of the ethics of Christ."

For this reason Albert Schweitzer was a Good Samaritan in the spiritual field as well. With his concern for all creatures and with his limitless sense of responsibility towards everything which was alive, he helped people to give a meaning to their lives.

During the First World War Schweitzer was refused permission to work in his hospital and passed a few months in a house near the sea in Cap Lopez. In 1917 he moved to France. After being in two internment camps he returned exhausted to Alsace after crossing the Swiss border. When he had recovered he worked as a medical assistant in a civilian hospital in Strasburg and also took up his old duties as protestant pastor in the church of St. Nicholas.

In 1920, after Easter, Albert Schweitzer went to Upsala in Sweden. He had been invited by Archbishop Nathan Soderblom to hold conferences in the university of that city. He held conferences and concerts in both Sweden and Switzerland and these enabled him to pay off the debts which had been contracted to keep his hospital going during the war. At the same time the idea grew within him of returning to Lambéréne.

In 1921 he published his memoirs of Africa under the title "On the Borders of the Virgin Forest." The thoughts contained in this book may still be considered useful in solving problems connected with promoting development—problems which have become very acute in today's world. In this field as well Albert Schweitzer was a Good Samaritan.

In 1922, while preparing for his new journey to Africa, Albert Schweitzer put the finishing touches to the published versions of the conferences he had held at Birmingham on "Christianity and the Religions of the World." Before leaving he rewrote the conclusion to his book "Memories of my Childhood." In both works he dealt with questions which were and remain at the centre of our concerns.

On February 14, 1922 Albert Schweitzer left Strasburg and on April 19 was at the headquarters of the mission at Andende. Nothing remained of the hospital except a small sheet-iron hut and the frame of a large bamboo hut. All the other buildings had rotted away or collapsed with the passing of time.

The following months, therefore, were devoted to rebuilding what had previously been there. In the autumn of 1925 the hospital was already able to accommodate one hundred and fifty sick people and the people who accompanied them. Large-scale famine and a dysentery epidemic forced Albert Schweitzer to move the hospital to another and larger area. With regret he decided to build the hospital for the third time, three kilometers higher up. On January 21, 1927 the sick were moved from the old hospital to the new. During the summer he built other huts in order to provide room for two hundred sick people and to the people who accompanied them.

On June 21, 1927 Albert Schweitzer was able to take a much needed holiday in Europe—in his work he was now surrounded by competent doctors and nurses. In Europe he began to travel and gave concerts and held conferences. During his free moments he worked on "The Mystics of the Apostle Paul" and wrote the first chapter of this book during his return journey to Lambéréne in December 1929.

Because the hospital was now known about for hundreds of kilometers all around, on his third arrival Albert Schweitzer had to deal with the problems of planning and putting up new buildings.

At the end of January 1932 he returned to Europe and at Frankfurt on the March 22 he gave the commemorative speech on the centenary of Goethe's death. He drew attention to the great humanitarian vision of Goethe, a man who very often appeared to him in the virgin forest as a "smiling comforter."

In 1949 Albert Schweitzer made his first voyage to the United States of America. The great generosity of the Americans and the donations collected in Europe enabled him to begin construction of a village for lepers. In 1951 he received the peace prize of German booksellers and was made member of the Academy of Moral and Political Science. In 1953 he was awarded the Nobel peace prize for 1952. With the money from this he was able to cover the houses of the leper village with corrugated iron and thus make them more lasting and resilient.

In 1954 the village was inaugurated and was given the name of "light village." This was because it provided a little light in the dark life of people who were subject to great trial. It was for obvious reasons that the members of this village said that Albert Schweitzer had built a hospital for these sick people. And it is in this context that Schweitzer especially revealed himself as a Good Samaritan.

On November 4, 1954 he was presented with the Nobel prize for peace at a ceremony at Oslo—the prize had previously been awarded in his absence. He took advantage of the occasion to stress that war is inhuman and was an evil as malevolent as ever. The speech was published until the title "The Question of Peace in Today's World" and over the years has not lost its topical relevance.

The threat of atomic war led Albert Schweitzer to break the silence on such a subject which he had maintained prior to that moment. On April 23, 1957 he made an "appeal to the world" on Radio Oslo and called for a halt to atomic experiments. The unsuccessful results of the negotiations between Russia and the United States of America led him once again to shake the conscience of the world. The three speeches he made appeared in the form of a book under

the title "Peace or Atomic War."

Two years after atomic experiments were renewed, and in conjunction with Bertrand Russell, Martin Niemoller, Robert Jungk and others, Albert Schweitzer launched an "Appeal to Everybody. Atomic Experiments do not Contribute to Peace." The appeal was published at Easter in 1962.

It was emphasized that there was no justification for the radioactive pollution of the atmosphere and to his great joy he was allowed to see the banning of atomic experiments in the atmosphere.

Unfortunately, present-day realities well show us that a real and acceptable solution has not yet been found to this major problem.

In 1959 Albert Schweitzer returned for the fourteenth time to Lambéréne. The hospital by now was able to give constant treatment to about six hundred people. The number of patients was constantly increasing.

On January 14, 1965 greetings and congratulations arrived from all over the world—it was Schweitzer's ninetieth birthday. Until the middle of august he was able to be content at the state of his health, but his strength then began to diminish. On September 4, 1965 he passed away, at 11.30 in the evening. On September 5, at 3 o'clock in the afternoon, he was buried in the presence of the whole of the population of the area.

His thought and his work continue to bear fruit. This reality will become ever more valuable if people reflect upon what a young person declared after visiting Lambéréne: "My name is not Albert Schweitzer and in no way do I want the newspapers to talk about me. But I am unable to avoid the constant question: where is my Lambéréne?"

The writings which Albert Schweitzer left behind him at his death have already been published, or soon will be. They well show us that his thought and ideas continue to be of great contemporary relevance. They have a great impact upon the reader.

The hospital of Lambéréne remains a living testimony to the Christianity and sense of mission which were behind its foundation. Those people who work there in difficult situations and offer their services to those who are less happy than they, and those who donate funds so that the hospital can continue its work, demonstrate in significant fashion that the call of Jesus to follow Him is constantly heard.

In an age in which many men doubt that existence has a meaning and find great difficulty in finding the path they should take, the life and thought of Albert Schweitzer should be considered a source of great and valuable help.

The path which leads to a life which is full, is open to all those who identify with Albert Schweitzer's definition of the destiny of man: "His vocation is to be a channel for the love of God here in this imperfect world."

Rev. RICHARD BRULLMAN
President of the International Association for the Work of Dr. Albert Schweitzer in Lambéréne, Switzerland

SUSANNA AGNELLI

Florence Nightingale

She became famous as the "Lady with the Lamp" bending with her lantern over the British soldiers she was nursing in the field hospitals during the 1854 Crimean war.

In reality, however, that was the only real first-hand experience she ever had with the wounded and sick, during the months she spent on the Crimean front which spread her reputation far and wide and began to build her up as a public figure, and almost a legend in her lifetime.

But there are other aspects in which those involved in nursing even today, often without realising it, continue in the footsteps of Florence Nightingale.

Florence was born on 12 May 1820 into an artistocratic, but above all, cultured family. The Nightingale home was frequently visited by the leading intellectuals of the time, with guests, not only from England but also France, Italy and America.

Between the ages of 20 and 30 she cultivated a keen interest in caring for the sick, and felt called to it almost like a religious mission.

The first chance she had to practise her vocation publicly was offered to her by Sidney Herbert, a family friend and Secretary for War. In October 1854 the articles written by The Times's Crimean war correspondent fell like a bombshell on the tables of the British middle and upper classes—the only people who read the newspapers: he described in the dreadful suffering of the soldiers with all the gory details, and addressed the controversial question of the complete inadequacy of health care in the army. The Government, which was waging in a war that enjoyed the support of public opinion which showed a strongly patriotic spirit and held out great expectations, found itself the target of bitter criticism on all sides.

Herbert asked Florence Nightingale to select and recruit a group of nurses and to leave with them for the Crimean front. He knew that he could rely on one of Florence's main qualities: her organisational skill.

For the first time in British history women had been asked to play an active role in a theatre of war (there were 38 of them, 14 lay women, 10 Catholic nuns and 14 Protestant sisters). The difficulties were many, and there was constant friction with the army officers who where reluctant to give up any of their decision making powers, even regarding health matters. Furthermore, Florence Nightingale's authoritarian character and the way in which she obstinately steamrollered through anything that fitted her convinctions and levelled criticism at the British Army did little to ingratiate her with others in the course of her mission.

While the army officers and doctors squabbled daily with Florence Nightingale in the Crimean, back at home the legend of the Lady with the Lamp began to take shape. The war was recounted in instalments in a popular weekly, the *Illustrated History of the Expedition to the Crimea*, using drawings to depict the most important events. In February 1855, the magazine published the portrait of a young lady wearing a cross around her neck and carrying a lantern; it did not name her, because she was intended to stand as the symbol of all the British women who where working for their country, and also because Florence Nightingale was only known to a small élite at that time. But when she returned to England in the spring of that year, her fame soon spread. She was the first woman to receive a medal from the Queen for services to the nation. Her stereotyped images were published increasingly in all the most popular magazines.

The Government asked her to write a report on her experiences in Crimea. She published a report over 800 pages long "to vindicate the thousands of men to had succumbed to disease but who could have been saved if they had been given the proper care", as she herself declared. One of her qualities was that he always looked behind the surface of events to try to seek out the underlying reasons for a particular problem and hence find the most appropriate remedies. That is why this report not only set out the facts, but criticised the overall lack of organisation and the inadequacy of the army medical services. But the figures on the war themselves spoke eloquently: 2,700 soldiers died in battle, 1,800 soldiers died of their wounds, but the vast majority of the dead—about 17,000—died of diseases contracted in a climate that was very different from Britain's, living in atrociously unhygienic conditions.

Florence's experience in the Crimea enabled her to begin working out her own concept of health care based on the key idea of prevention: cleanliness, a healthy diet, and good ventilation were the basis of good health. But her interest in nursing was not a purely personal fixation of Florence Nightingale's. What was then called the "sanitary idea" had already been the inspiration of philanthropists, politicians

and poets back in the 1840's; it was the social situation in Britain, at a time of far-reaching and rapid changes, that highlighted the whole question of the living standards of the working classes and the search for ways of raising them, and made it a matter of public debate. The expansion of industry had made the working-class districts of many British towns overcrowded, unhealthy, and unhygienic in every respect, with homes without any facilities to guarantee hygiene. Many surveys into living conditions showed an urban population that was largely poverty stricken and often ill because of the wretchedness of their daily lives.

The hospitals catered for the poor while those who could afford it were treated at home by their own doctors. Hospital care was in a disastrous state, and many patients died within the first twenty-four hours following admission. Florence Nightingale became involved in the public debate and in measures to improve the situation and played a decisive part in creating the modern nursing profession, to the extent that even today in nursing schools' textbooks she is depicted as an initiator and innovator.

In 1860, using government funds over which she was given freedom of management, she founded the Nightingale School for Nurses. This was not only intended as a means of founding nursing as a profession that had never existed before, but above all it was designed to break down the prejudiced view that nurses were uneducated, of dubious morality and even former prostitutes.

At the same time, many other schools were established to train nurses, but in most cases they based their approach and character on the "Nightingale method." Florence laid down in paintstaking detail the duties and working methods, trying to make clear the difference in the role and function of doctors and the nursing personnel. During the practical training period in hospital, a monthly personal progress report was made on each of the probationer nurses, including both their technical skills and their moral and personal qualities (for example punctuality, reliability, ability to stay calm). In her writings, Nightingale said that the nursing profession was an art that had to be learned through practice and discipline and by moral training, and was not simply a matter of storing up technical information.

When planning the school, Florence sent out complex questionnaires to various institutions in France and in the German-speaking countries in order to find out more about their training systems for nurses. In those years statistics applied to social problems was becoming standard practice, and in order to be credible and acceptable to

the public any claim had to be supported by facts and figures. Being endowed with a highly scientific mind, and by nature being used to do everything thoroughly, Florence Nightingale went out and argued her views using masses of data which she collected personally. Her questionnaires comprising hundreds of questions with which she flooded England and the colonies of the vast British Empire and the other European countries soon became both famous and feared.

The Nightingale school provided access to the nursing profession to women from every class, regardless of their social background or financial situation. The trainees were therefore divided into five categories, some receiving remuneration and others paying their own board and lodging, since the school itself was designed as a residential college and the training was free of charge to all.

Although at the beginning it was difficult to find trainees, as the years passed increasing numbers of women enrolled, not only at the Nightingale School and the other nursing schools, but with many other vocational training courses. In the last twenty-five years of the nineteenth century, the history of women in British society underwent a major change of direction. Women were increasingly leaving their homes: industrialisation had taken away many opportunities for craft work in the home; and now not only proletarian women but also lower-middle class and middle class women were looking for jobs outside the home.

Meanwhile, the campaign to give women the franchise was in full swing. Florence Nightingale signed various petitions submitted by the suffragettes but she did not take a direct part in the campaign, partly because she believed that she had another mission, but above all because she was sceptical about the political maturity of women and feared that they would merely vote along party lines following their husbands instead of supporting specific women's issues. But Florence never had any doubts about women's abilities or their right to live an independent life, and in her diary written in 1853 she said "I have no intention of hanging about around my mother's sitting room... I shall go out out to find a job. Man is born for the world, woman for the family. Women must be born for the world to find joy and to practise their skills."

She applied one of the key ideas of all her work, namely the need to give medical personnel proper training, to one particularly sensitive area: midwifery. As in every other hospital ward, there was a high death rate among nursing mothers in all British hospitals in the mid-19th century. Indeed, the statistics showed that the death rate was much higher among mothers giving birth in hospital than among mothers having their babies at home. The problem was therefore to provide women wishing to give birth at home with properly trained midwives to assist them. Here again, as for nurses, Florence Nightingale's aim was to

transform an occupation that by tradition had been exercissed by uneducated women into a modern profession based on sound scientific knowledge.

In 1862 Nightingale inaugurated a six-month training course for midwives. The school had a towfold social purpose: to provide training above all for women from the poorer classes living in the countryside, and to ensure that qualified midwives would work for four years in the houses of the poor in their own areas, receiving a wage from their parish.

Her initiative could scarcely be called a success in terms of the actual immediate results. In five years, only 40 midwives had been trained. Few women enrolled because the country parishes were not able to afford to pay for their candidates, but also because the women who were already practising midwives could not afford to give up their work to take six months' training.

But Nightingale had the capacity to publicise her own schemes and attract interest and debate around the principles that underlay them. In the case of the midwifery school one very important aspect was that it had drawn the attention of the public and the medical profession to the need to improve the quality of care at childbirth. But it was to take another 40 years before midwifery was officially recognised as a profession and governed by Act of Parliement.

Nightingale's interest in caring for the poorer classes inevitably caused her to take part in the heated political debate in the 1860s on the Poor Laws, which were designed in particular to regulate the institutions that took take in the destitute, lunatics and the sick. In London alone 20,000 people lived shut up in workhouses just because they were poor and often old, where they worked if they could, in exchange for board and lodging. More than one third of the inmates were ill and many died because of a lack of medical care.

An association was founded to improve the quality of nursing care in workhouses supported by such outstanding people as Charles Dickens, John Stewart Mill and Nightingale herself. In the 1870s a government programme was set in mition to build new hospitals for sick paupers, but work proceeded slowly due to a shortage of founds and red tape.

Most of the people trained at the Nightingale School were sent to work in the workhouse infirmaries to try to make them somewhat less inhuman. From this point of view the school played a very useful social role because the nurses trained in other courses preferred to take better paid jobs in the hospitals.

But Florence Nightingale took

up a different position to that of the other reformers because of her radical views about the workhouses. Even though she though it was essential to improve the quality of nursing care provided by these institutions, for her the real problem was the very existence of workhouses themselves. In 1867 she wrote I believe that the purpose of nursing is to care for the poor in their own homes. .. I want to abolish all the hospitals and surgeries in the workhouses. But it is futile talking about the year 2000.

She devoted a great deal of time to one issue, which is high on the social policy agenda today on the eye of the year 2000: the provision of home care. When whe was asked in 1874 by a member of Parliament, Mr Rathbone, to found an association of home nurses in London, Nightingale replied that it was first necessary to carry out a survey to see whether there was any such need, and if so how great that need was. After distributing one of her customary lengthy questionnaires, she found that in London there were already twenty-six associations dealing with home nursing, managed by lay benefactors or religious groups. What was missing was suitable vocational training for nurses. Associations usually sent a charitable gentle-lady accompanied by a woman from the lower classes to the houses of the poor, both of whom were fairly ignorant of medicine and had no specific working method.

In April 1876 Florence Nightingale wrote a letter to the Times launching a campaign to seek financial support for the new association to train home nurses to look after poor sick people; the Promoting Committee included doctors, reformers and parliamentarians. Three training schools were opened. The students were required to have a medium/high sociocultural background since they would be working under difficult conditions and would have to be able to organise and run their work with a great deal of autonomy.

To Nightingale's mind, home care was not merely a matter of looking after people at home when they were sick. For her, a nurse should be able to give patients information about hygiene and making the most of all the sanitation facilities available to them.

The leading social issues in late nineteenth century Britain were mostly debated in theory and practical measures taken to tackle them by private citizens and associations. Even so, the radical Liberal reformers believed it was necessary for Government to play a more direct part in helping the poorer classes. Florence Nightingale shared this view and in the course of the years that followed, even though she accepted occasional donations she virtually never appealed again for public support to finance her school. For she believed that it was the duty of Government to provide training for the nurses looking after the sick poor, both in the hospitals and at home.

The seventy-fifth birthday of

Queen Victoria in 1887 provided an opportunity to finance many social schemes. Thanks to wise diplomatic moves by reformers and benefactors the Crown agreed to provide funds to open the Queen Victoria Institute to train home visitors to nurse the poor. The school curricula were based on the ideas laid down by Florence Nightingale. This was the first step in a process that was to lead to setting up a nationwide system of district nursing in the century that followed.

In the middle years of her life, Florence Nightingale played a part in British public life at several levels. The issue with which she was concerned were all linked to one interest: harmonising health care. Through the years she studied, extended and applied this to many different spheres.

In terms of social policy, as we have seen, her attention wa devoted to looking after the poorer classes. Her voice was heard loud and clear in relation a number of British international policy issues, for which she examined and suggested solutions.

Like most of Queen Victoria's subjects, Florence was also proud of Britain's growth as a colonial power. In the second half of the nineteenth century the British Empire reached the peak of its expansion. As Asa Briggs has put it, Britain was the world's workshop, building site, postman, banker and clearing house.

In order to maintain the Empire and its primacy on the international scene the British Government built up a vast army. Her Crimean experience enabled the Lady with the Lamp to experience first-hand the daily lives of the soldiers. After returning from the Crimean she did everything possible to improve the health and hygiene organisation in the military barracks as one of her constant concerns. In particular she was horrified by the large number of soldiers, mostly recruited from the working classes, who died of disease and the lack of proper medical care.

In the colonies the situation was even worse because of the climate, and diseases unknown in Britain.

In 1856 Florence Nightingale pursuaded the Government to set up a Commission to improve the living conditions of the soldiers' quarters throughout the country. From the information collected by the Commission in the course of numerous inspections which were analysed by Florence, she proposed a set of remedies. Thanks to her views, improvements were made which considerably reduced the percentage of soldiers dying of disease. In 1855, before the "Nightingale treatment" the death rate was 17 soldiers out of every thousand, while in 1860 the number had dropped to 9.9 per thousand.

The revolt against the British in India in 1857 threw the country into turmoil. The many troops immediately sent in to quell the trouble were decimated by tropical diseases.

From the heated debate on the Indian question in Parliament, the newspapers and sitting rooms of Britain, it became urgently necessary to introduce measures not only to strengthen the Army but also to change the way civilian life was organised in the colony.

Florence Nightingale decided to enter the fray and study a system to improve the health situation and the quality of life of the British in India and the Indian people themselves. The amazed officials of 200 British military stations sitting on the Commission found themselves confronted with sheets and sheets of questions signed by the strange lady.

Her report on the data collected was successfully submitted in 1863 at the Edinburgh Congress of national associations for the advancement of social science. In the presence of the Prince Consort, Florence Nightingale read out her comments on how people can live and not die in India.

The health care plan involved improving hygiene in the home, introducing irrigation and water distribution methods, and innovations in farming techniques. She even launched the idea of giving loans to Indian peasants through a special rural savings bank to enable them to own the land they worked and to irrigate it with water purchased from the British Government. She thereby though she could change Indian famers along the lines of the model used for small-holders in the British countryside, but she failed to take account of the profound differences in mentality and culture.

India's problems were to remain a source of great concern to her for over 20 years, but her proposals were not widely applied by the governors of the colony.

The "Nightingale method" of training health care personnel found its way to the most distant of British colonies. In 1866 the new hospital in Sydney, Australia, was at the centre of heated controversy over the poor quality of service it offered the patients. But Florence's fame had already travelled the seas: to solve the problem the Secretary of the region, Sir William Parkes, asked the Nightingale School to send a group of nurses willing to move to Australia; six of them left and inaugurated the recently adopted British method in Sydney.

After the nineties, Florence Nightingale gave up all public life. Now old and sick herself, she only took part in the debate or health care issues, writing long letters from the bed to which she was now confined.

Many of the conditions that had driven her on to fight her battles had changed. With new scientific knowledge abut hygiene and the spread of infection, the service offered by hospital wards and the patients were no longer only the poor, but also members of the middle

classes who paid for admission.

But the Nigtingale School was no longer able to keep pace with and adjust its curriculum to the changes taking place in a field which the school itself had helped to modernise.

Florence Nightingale died on 13 August 1910.

But her witness did not die with her.

Florence Nightingale, in her earthly life, not only made such an effective and radical mark on the world of health care, but she also managed to endow her work with the value of a universal and enduring example.

Hers was a great act of Christian witness.

The pursuit of scientific and material progress in the work of Florence Nightingale was never separated from the utmost concern for the human persona and for man's moral and spiritual dignity.

These, in my view, are the most outstanding features of her witness: the central position she gave to the human person in the pursuit of scientific progress, and the priority she attributed to meeting the needs of the sick when developing health care.

Florence Nightingale teaches us that the ultimate purpose of both scientific research and medical care must be to put ourselves at the service of man, to alleviate earthly sufferings.

She urges us to focus not on the pure and stark scientific achievements, but on the real and priceless lives we are able to save.

She reminds us that in their human dignity, it is the sick rather more than their sickness considered with scientific abstraction, to whom our attention must be directed.

This is why I have always admired Florence Nightingale: a woman with great intellectual vision and a profound Christian spirit, who showed us the way to combine the principles of the Hippocratic Oath with the love of the Good Samaritan.

Today's society is confronted with extremely difficult decisions. In the darkness of the unresolved relationship between ethical/spiritual values and medical/scientific progress, the witness of Florence Nightingale stands like a beacon, as a light of hope for us all.

Hon. SUSANNA AGNELLI
Italian Minister of Foreign Affairs

CORNELIO SOMMARUGA

Henry Dunant

Henry Dunant certainly qualified as a Good Samaritan in our time. His work and his words—which, while profoundly Christian, are universal and independent of any religion—still influence our lives today.

For Henry Dunant was at once

1) *a Christian* who, through his faith and his writings, devoted most of his life to spreading Christ's message of brotherly love among all human beings, even in wartime, even among enemies;

2) *an active Good Samaritan* who, just like the biblical Samaritan, was on a journey when he came across great suffering and an urgent need for succour, who stopped, improvised, mobilized, and put aside the trivial in order to deal with the essential;

3) *a media man*, capable of mobilizing the public opinion of his time with the book "*A Memory of Solferino"*—an eyewitness account of the suffering and abandonment of thousands of wounded soldiers lying on the battlefield on 24 June 1859, and a call for action through the example set by the "Good Samaritan of Solferino;"

4) *a diplomat* who, as a pioneer of the humanitarian cause, persuaded major governments of the time to create National Red Cross Societies, to come to the negotiating table, and to sign the first Geneva Convention in 1864;

5) *the creator of a network of goodwill* who, like the Samaritan in the parable, succeeded in mobilizing people, not only in the short term but for many years to come—for with one single act his example became a model for us all, spreadling from country to country, reaching all social levels and touching every continent;

6) *a universalist* whose humanitatian message and deeds, like those of the biblical Samaritan, are unconditional, transcending all political and relgious prejudice, advocating assistance without discrimination; the universal scope of today's international humanitarian law and of the Red Cross and Red Crescent Movement can be directly attributed thereto;

7) *an idealist and a realist* who, knowing that charity could never be a substitute for justice, nor humanitarianism for peace (though he was awarded the first Nobel Peace Prize in 1901), always maintained the two distinct approaches;

8) *a committed relief worker* who always remained neutral: Henry Dunant's example at Solferino in 1859, and later in France in 1870 and 1871, still serves as a source of inspiration to the ICRC as it pursues its activities in 30 conflicts today—humanitarian activities must be practical, neutral, impartial, and undertaken for all victims of war, without distinction. "*Tutti fratelli"*—"They are all brothers," said the women of Castiglione assisting Henry Dunant in the Chiesa Maggiore.

The words and deeds of Henry Dunant—who died on 30 October 1910, the same year as Florence Nightingale and Leo Tolstoy, two personalities he admired—are just as valid today. His humanitarian example is perpetuated by the ICRC, or the International Committee of the Red Cross, of which he was one of the five founding members; by the *National Red Cross Societies,* that were created upon his recommendation and as a result of his efforts, and by their Federation. The right of victims of conflicts to receive protection and assistance is embodied in international law by the *Geneva Conventions.* The *red cross emblem* is—like the subsequently recognized red crescent—the universally recognized symbol of respect due to the wounded and sick, and also to the people who care for them, the vehicles that transport them, and the buildings that shelter them. These two emblems symbolize humanitarian action today.

Yet the example that began in Solferino should not be applied in wartime alone. It must also be pursued *in peacetime,* either to assist the victims of natural disasters or those in distress—that is the role of the National Red Cross and Red Crescent Societies, and their Federation.

Based on Good Samaritan Henry Dunant's example, it is now up to us to perpetuate and expand on the deeds and the law that began in Solferino, so as to ensure—even at the hight of wartime violence—respect for life and the dignity of every human being through *practical humanitarian action* by the victims' side, through proclamation of the *fundamental principles,* and through codification and implementation of *international humanitarian law.*

If Henry Dunant's work has been continued from the time of Solferino up to the present day, it is not merely because of the memory of an act worthy of the Good

Samaritan in Christ's parable—an act that went on to become the linchpin of a world Movement and is now firmly established in international law—it is also because humanitarian action is now inextricably linked with a number of *Fundamental Principles,* which guarantee its authenticity and effectiveness. These Fundamental Principles were formally proclaimed 30 years ago at the 20th International Conference of the Red Cross, held in Vienna in 1965.

Allow me to cite and briefly comment on these seven Principles, since they are in harmony with the worlds and deeds of Henry Dunant and with the spirit of Christ's Good Samaritan.

• *Humanity:* The principle of humanity means endeavouring to prevent and alleviate human suffering wherever it may be found. This concept exists in all religions, all traditions, all civilizations, and all philosophies. It is vital nowadays that we understand that all human beings make up one family, no matter to what religion, traditions, civilization or philosophy they may belong.

• *Impartiality:* Impartiality means recognizing that all men and women are equal, that care must be provide equality and according to need. It means we should act impartially and without prejudice or discrimination, like the Good Samaritan, like Henry Dunant in Solferino.

• *Neutrality:* The ICRC enjoys the confidence of all because it does not engage in political, racial, religious or ideological controversies, but endeavours merely to alleviate human suffering and afford ubiased assistance and protection to those who need it. It was never the intention of the Good Samaritan or of Henry Dunant, nor is it the intention of the present-day ICRC to pass judgment, either on those who cause the suffering or those who fail to provide assistance.

• *Independence:* If humanitarian action is to be respected, it must remain independent as regards politics, religion and finance.

• *Voluntary service:* This principle underscores the purposeful and disinterested nature of humanitarian action.

• *Unity:* Unity signifies the cohesion and harmony of the National Red Cross and Red Crescent Societies, as well as their willingness to recruit, without discrimination, members and workers who are called on to pursue humanitarian activities throughout the country's territory.

• *Universality:* The humanitarian spirit knows no borders. It must prevail everywhere, and at all times. The parable of the Good Samaritan and Dunant's *A Memory of Solferino* are not relics of times gone by, for they call on each and every one of us to lend a helping hand whenever and wherever needed.

Henry Dunant's message and work are as relevant today as they were more than a century ago. An ardent Christian whose initiative in Solferino was worthy of the Samaritan of the Gospel, he succeeded in mobilizing public opinion and created a network of goodwill at all social levels and in all countries; he was an able diplomat and a universalist ahead of his time. But above and beyond all those qualities and all those achievements, it is the words and deeds of Henry Dunant, an idealist yeat a realist, that still serve as a source of inspiration for millions of men and women today, that represent hope in the face of despair, that bring a message of life in the face of death and that, even in the midst of hatred, sow the seeds of fraternity and peace.

Henry Dunant was a Good Samaritan of our time. His life and work remain symbols of hope, compassion and solidarity; as Victor Hugo wrote to Dunant, *"You are arming the cause of humanity and serving freedom."*

Dr. CORNELIO SOMMARUGA
President, International Committee of the Red Cross (ICRC)

ANDRÉ RECIPON

Raoul Follereau: Apostle of the Lepers

Associations in over thirty countries bear his name and continue the battle he conducted his whole life against leprosy and against all forms of leprosy.

Who was this Raoul Follereau whose name gives rise to so much devotion on the part of people of all ages and from all social backgrounds?

A man with a great heart, an advocate of the magnificent word.

He was born in Nevers in 1903. His parents were owners of a small business which worked for the agriculture of the region. They were neither rich nor poor. They enjoyed a simple and truly honest standard of living. In 1914 his father was called to arms and in 1916 was killed at Verdun. At that time Raoul Follereau was thirteen years old.

In 1920, when he was seventeen, he published his first poems and his first book of love:

"To live is nothing—you have to love.

To love you have to pray: love is baptism!

Blessed are those that love because they will

be blessed by the Lord."

In 1923, at the age of twenty, he gave his first talk. It was at a ceremony to commemorate the victims of the war. The title of the talk was: "God Is Love."

"The heart is the key to heaven.

It is the great force of the universe,

the only invincible force, the only creative force"

"Let us love each other—this is everything."

In the idea of love can be defined and captured the entire philosophy and work of Raoul Follereau. His incredible destiny began on the path of charity.

In 1924 he graduated in law and letters. He then left to perform his military service. When this was over, a year later, he married. He then enrolled as a lawyer at the forum of Paris and became part of an important law office. But the first case in which he was called to be the defense lawyer was a divorce case. He then left the forum and became secretary in the editor's office of an important Paris newspaper.

In 1927 he set up his first association with the help of some poet friends of his, including my grandfather Michel Rameaud and a young priest who would later become Mons. Ducaud-Bourget. This association was called "*the League of the Latin Union for the Defense of Christian Civilization against all forms of Paganism and Barbarity."* He would write its extensive program much later.

In 1929 the Ministry of National Education gave him a special mission. The ministry was in his debt because of a question arising from an examiner whose honesty had been severely called into doubt—Follereau had had to call for disciplinary sanctions in the case. His mission was to investigate the causes of French influence in South America. After eight months he returned with two reports. One was the official report on his mission. The other was entitled: "*the Anti-Religious Laws of 1905 have Betrayed France."*

In both reports he declared: "all the clergymen and members of religious orders which you have banished from our schools left for the world. They have created schools, colleges, and universities, all of which have grown in number, from Buenos Aires to Caracas and from Rio de Janeiro to Valparaiso. Everywhere you go French is learnt and ancient French songs are sung, and I was welcomed by both!" Obviously enough, this was not what the ministry wanted to hear!

During this voyage an important Argentine newspaper—*La Nación*—asked him to write an article on "The steps of Father De Foucault." He therefore made a number of journeys to the Sahara and on his return from each one wrote articles and gave talks. The proceeds enabled him to finish the work on the Basilica of El Goléa and to build the chapels of Adrar and Timimoum. At that time the "*League of the Latin Union"* became the "*Charles De Foucault Foundations."*

It was during one of these journeys, in 1935, that he encountered lepers for the first time. He was on his way through the Sahara to the Niger. This is his own account of what happened:

"How did this adventure which would last for the whole of my life actually begin? It was because my car broke down! I had to do an article for an important Argentine newspaper and I was in the center of Africa. That morning our car had passed through a village when we had to stop our journey because the engine was overheated.

After a short while a number of frightened faces came out of the bush, then a famished body. I called on them to draw near. Some fled but some others—no doubt the most courageous— remained where they were. But they did not stop looking at me with their staring eyes so full of pain.

I said to my guide: "Who are these men?"

"Lepers," he replied.

"Why are they there?"

"They are lepers."

"I understand but wouldn't it be better for them to be in the village? What have they done to be so excluded?"

"They are lepers," replied the man in taciturn and stubborn fashion.

"But are they at least treated and cared for?"

At that point the person I was speaking to shrugged his shoulders and went away without saying a word. That day I understood that there was a crime which could not be forgiven. A crime without a memory and without any prospect of an amnesty—leprosy."

Shortly afterwards the First World War was about to break out. The declaration of war found Follereau in Argentina. He returned to France, was called to arms, and in 1940 managed to escape capture. In 1940 he arrived in St. Etienne at my grandfather's house, and for the rest of the war my grandfather acted as his personal secretary.

From 1940 to 1942 he went to communes throughout France and tirelessly held the same conference on the subject of "what the world owes to France." His aim was to restore confidence to the French who had been rudely shocked by the defeat which had recently been inflicted upon them. This was the first occasion I heard him speak. It was towards the end of 1941 and I was sixteen years old. One year later, in 1942, the conflict became worldwide. At an international level all the nations of the world became indirectly or directly involved in the conflict. At a national level the French began to divide into two groups which were separated by a hatred so terrible that it is still alive today. With the intelligence which characterized him he clearly perceived from 1942 onwards that the "Marshallists" and the "Gaullists" would never become reconciled. The appeal of the mother superior of the sisters of our lady of the apostles—which is where he was hidden—was a crucial factor in leading to the decision to establish Adzopé and thus to begin the "*battle against leprosy.*"

This was in November 1942. The mother superior had returned from a difficult and dangerous journey. She had discovered an island in the Abidjan lagoon where a group of rejected, abandoned and damned lepers lived in a state of desperation.

She then conceived of a project to build a small town for them in the middle of the virgin forest—a plan which respected the local health regulations. Each family would have its own little house and a garden, and in this way everybody would have the feeling of being free.

I remember that at that time *there was no medical treatment for leprosy*. The exclusion of the victims of leprosy was a result both of panic on the part of healthy people and of a policy of abandonment by doctors. There was also the impact of the health regulations of the time.

Like Fr. Damien, who has recently been raised to the glory of the altars by the Holy Father, only clergymen and members of religious orders agree to leave everything—family, friends and country—to go and live in a faraway region which is often hostile and unwelcoming and spend their lives with men and women

made lepers by our selfishness. These missionaries (of whom two out of every three are French) have written the most beautiful pages of the book of charity.

In order to build the town for lepers of Adzopé funds were needed. Raoul Follereau dedicated himself to the question. For ten years, and accompanied by two nuns, he trod the roads of France, Belgium, Switzerland, the Lebanon, Algeria, Tunisia, Morocco and Canada. He held 1,200 meetings in ten years! The first took place on 15 April 1943 at the municipal theater of Annecy.

"By that time I had been taken by leprosy. I don't mean that I had caught the disease. I was its happy prisoner. I had seen too much misery, too much pain, too many faces afflicted by the evil and by shame, too many faces without hope."

The conferences he held led him to receive a huge correspondence from sick people, medical doctors and missionaries, all of whom said the same thing: in this world there is much more than Adzopé! They told him that "*millions of people are without treatment, succor or love!*"

He then left for Africa, Asia, and South America. He held 296 conferences in thirty-five countries and was able to see how widely spread leprosy actually was.

On September 20, 1952 he made an appeal to the United Nations:

"*The neglect by the civilized nations of this question is such that today no country is able to give even an approximate estimate of the number of lepers within its borders. At the present time it is not possible to declare that there are a few million lepers suffering on our planet...*

Since I began my travels around the world to investigate local situations and to ask the most qualified people about the way things are, I have come to the certain conclusion that there are at least twelve million lepers in the world—that is to say one for every two hundred inhabitants...In very many countries leprosy remains a condition of which to be ashamed. Lepers are hidden, kept from sight, and shut up. This is true both of families and of nations."

He was able to speak with even greater energy because in 1952 that is to say ten years after the launching of the "battle against leprosy"—a drug which cures leprosy had been discovered *for the first time,* namely sulphonics. The joy caused by this discovery to both the sick and those responsible for their treatment and care cannot be imagined. *Finally,* medical science had triumphed over a disease as old as the world. *Finally,* those afflicted by leprosy would be able to be men like other men.

In order to gain the world's attention Raoul Follereau took a powerful initiative. In 1953 he launched the idea of a *world day of leprosy* to be celebrated on the last Sunday of January. He defined the aims of this initiative in the following way:

• to ensure that those suffering from leprosy are treated and cared for like other sick people, with respect for their freedom and their dignity as men;

• to ensure that healthy people no longer have their absurd and at times criminal fear of this disease and of those who are afflicted by it.

From the first day (31 January 1954) we were able to witness a

unique and wonderful event: people who lived in towns near to lepers marched "to the lepers." The next year, in 1955, the day was celebrated in sixty countries. In 1961 it was celebrated in one hundred and sixteen nations of the world. This initiative of Raoul Follereau, which involves the collection of funds from healthy people or solidarity with lepers in countries where the disease is endemic, took place for the forty-second time on January 29, 1995 in a large number of countries. In 1968 he asked me to continue his work and inspired by this man of genius I proceeded to establish the necessary national and international organizations and structures. Without sharing the optimism of the World Health Organization, we can state that leprosy is about to be defeated and that an important role in this has been played by the organizations which bear the name of Raoul Follereau and carry out his work "*against leprosy and all forms of leprosy."*

On December 6, 1977 Raoul Follereau returned to the house of the Father after finishing his life and his work. I cannot finish my paper without reference to the role played by his wife, Madelaine Follereau, in the battle against leprosy and against all forms of leprosy, and without reading you some pieces written by Raoul Follereau on Christianity and on charity. In this way perhaps you will understand why this men exercised such a great influence.

in the first volume of his book "The Only Truth is to Love Each Other," which was published in 1966, Raoul Follereau writes as follows:

My Greatest Fortune

"The greatest fortun
e of my life has been my wife. When we decided to get married our ages together did not pass the thirty mark. Our parents were wise and smiled...Some fifty years later it is we who now smile.

"I have never gone on a journey without her. She has accompanied me in all the leper colonies of the world. She has been my support, always. And at times my consolation.

"I confess that I barely manage to control my irritation when some good woman says to her, and with a certain hidden envy: "But you go on good journeys."

"Most of the time she smiles without answering. Perhaps she thinks of that night which we spent in Bolivia, in a hut which the Quichuas Indians had given us...My wife was suddenly attacked by severe appendicitis. We were a thousand kilometers from the nearest doctor. During that moonless night I saw her doubled up and I heard her moan. To defend us and to protect her I had only a jammed pistol, two centimeters of candle and three matches. In that crushing darkness I had the strange and somewhat terrifying impression that my hair was going white, and I was only thirty years old.

"Or of that evening when the engine of our canoe stopped in the middle of Amazonia and we strove in

that night rent by our lamps to get to the bank of the river. We had to use tins as oars to get to reeds full of thousands of mosquitoes where enormous caymen passed the night.

"Only when you are in two are you invincible."

To finish I would like to cite those pieces on Christianity which appeared in 1948 in "The Age of Man," and those pieces on charity which appeared a year later in the work "Atomic Bomb or Charity."

The Age of Man

Christianity
has given to men
their only real freedom
their only lasting happiness,
their only just laws.
It has broken the chains
of slavery
and princes and kings
are made to bow
before its justice.

It has made maternity
into a holy and venerated task.
It has made the greatness
and tender power
of woman respected.
It has made the individual
into a man.

It has protected the child
"to whom belongs
the kingdom of heaven."

It has damned wars.
It has limited them
where possible.

It has created hospitals
and schools.
It has cared for, consoled
and healed without ceasing
for twenty centuries
in the name of that poor
man who said:
"Love one another."

Christianity is universal.
Its message is for all
the peoples of the world.

Its civilization is like
the face of Jesus...
Christianity
is revolution
through charity.

Atomic Bomb or Charity

Charity, light of our lives.
Charity, is not alms-giving.

Charity, source of every joy.
Charity, order of God,
reflection of his eternity...

Charity must be done
above all else
"for the love of God."
Without the love of God
who is the source of charity,
it becomes generosity, altruism...
It is very beautiful...
But it is not charity.

Charity
is the image of the face of Christ
on the face of the poor man,
the suffering, the persecuted...
Charity
is the history and the glory
of Christianity.

M. ANDRE RECIPON
President of the Raoul Follereau Group, France

SIMONE TONINI

Abbot Hildebrand Gregory

Introduction:
Monk or Good Samaritan?

The word "Abbot" tells us that we are talking about a monk. We immediately ask ourselves how it was that a monk could also be a "Good Samaritan" in the common sense of the term.

A "monk" should live a hidden and quiet life within the walls of a monastery, dedicated to prayer, to study, and to work. How can he be a "Good Samaritan" if he takes care of orphans, the poor, the sick and the elderly who live in the world outside? If he dedicates himself to such activity, can one really say that he is consistent with his vocation? These are legitimate questions if we are presented with a monk is held up as a Good Samaritan of our times.

But it is precisely this tandem of monk and Good Samaritan which attracts our attention to the person and the work of Abbot Hildebrand.

His Eminence Cardinal Fiorenzo Angelini, the first biographer of this Servant of God and also his spiritual son, understood this very well when he entitled his book "*from the hermitage to the crowd,*" a title which I would like to translate in perhaps more exact terms with the phrase "*from the monastery to the people.*"

1. Who was Abbot Hildebrand?

Abbot Hildebrand was born in the small towm of Poggio Cinolfo, in Abruzzo, Italy, on May 8, 1994, and was baptized with the name of Alfredo Antonio. He felt a strong attraction for the religious life from a very early age but he was allowed to enter a monastery of the Benedictine Silvestrine Congregation only at the

age of fifteen when he was given the religious name of Hildebrand. During the First World War he served in field hospitals in a variety of places, and with his own hands he touched the physical and moral ruins provoked by the war. It was during this period that he begun to think about helping young people to become useful and responsible citizens after the catastrophe of that war.

When the conflict had come to an end he finished his studies for the priesthood at the Gregorian Pontifical University of Rome, and graduated in philosophy and theology. For nine years he dedicated himself entirely to promoting and forming vocations to religious life and the priesthood. He also became a preacher and a very much sought after spiritual director. In 1933 he was nominated superior of the mother house of the order and in 1939 when the outbreak of the Second World War was in the offing he was elected Abbot General.

In previous years his activity had been very intense but during the war it was only limited by the time available. In addition to being responsible for his congregation—all the houses remained open and functional despite the very great difficulties in relation to communications, movements, food and clothes—he became ever more involved in helping communities and people in difficulty. He opened his monastery of St. Stephen in Rome to people in extreme danger, both Jews and others, and even found means by which to help refugees who were forced to live far away from their homes which were in the combat zone. One wonders how it was possible for such a man, who often had health problems, to live at such a pace. He ate very little, slept even less, was constantly moving around, and yet always found time for intense and lengthy prayer.

The plans which he had developed during the periods of calm of the First World War suddenly became of dramatic importance for him. He was the Abbot General and therefore had the authority to act. But for him authority meant first and foremost responsibility. He felt that he could and should act. The painful sight of children abandoned and underfed, often left in the streets to look after themselves and the easy prey of vice and disease, could not leave the Abbot Hildebrand indifferent to their fate.

In a place which had been given

him by a noble Roman family—a site which no other religious order wanted because the building was in ruins, the land was sterile, and there was no water—he managed to construct a house in record time with all kinds of materials that came his way. At first there were the "colonies." These were a kind of summer camp for children threatened by tuberculosis who often did not have a family or who were the children of parents who were too poor to take care of their health or their upbringing.

Abbot Hildebrand was not a man who could send these children back to their homes after a few months stay in these camps (even supposing that they had a home to be sent back to) or to return them to the institutions which had sent them to him. He dreamed about places where these children could find a roof over their heads, care, education, and above all else love and hope. These summer camps thus became permanent. This meant new buildings and structures.

The meager existing structures soon became insufficient to deal with the hundreds of requests that rained down from all quarters. A kind of wonderful avalanche began: barracks obtained as cast-offs from the army, then further boys, new buildings and then new places. Another six monasteries of the order were involved, other monks, other teachers and helpers. In a short time there were hundreds of boys and little later thousands.

And what about Abbot Hildebrand? How did he manage to keep everything in hand? As Abbot general he was required to travel and visit monasteries not only in Italy but in the United States of America, in Ceylon, in Australia and in India. It was he who had to find money, food, clothes, furniture, books and every other kind of necessity. It was he who had to find the staff, keep an eye on the administration, follow the construction of the new buildings, keep documents, manage the correspondence with ministries and such government offices as the ministry of health, the ministry of education, the ministry of public works, and many others.

Even though he had set up a kind of rudimentary office in a small room next to the sacristy of his monastery of St. Stephen in Rome, his more frequent office was the bus, the train or the car. The amount of correspondence he had to deal with was immense, and the same was true of the number of contacts he had with all kinds of people. In the office of the postulation we have more than thirty address books full of addresses and telephone numbers. He had a very strong sense of gratitude and he gave a receipt for every kind of help he received and was always punctual in thanking the

benefactor. He had begun with nothing and from nothing. He was poor and his order was also poor. He did not draw back from asking or from knocking, from going up the stairs of ministries, or from waiting for many hours (with humility and patience) in the waiting rooms of people who could help or were obliged to do help because of the jobs that they held.

2. The Founder

And here we touch upon another, in a certain sense unusual, activity of Abbot Hildebrand. He, a monk, thought also about infant girls. From many points of view they were in a worse situation than infant boys. He managed to organize a meeting of young women who wanted to consecrate themselves to God and to their neighbor.

He rented an old small monastery of the Capuchin friars, not far from where he had begun his work with children, and begun another incredible work of charity. In a short time the two institutions had thousands of children and provided them with schools and other services. Another six monasteries of his order opened their doors to children and the number of homes for infant girls grew rapidly as the female religious institution he had created attracted new recruits. Thousands of children, both boys and girls, found a welcome, new life, hope, dignity, and a future.

3. The Man of God

When faced with this unusual figure who was both a monk and a Good Samaritan certain questions immediately pose themselves to us.

How was Abbot Hildebrand able to engage in such extensive social and charitable activity and at the same time remain loyal to his vocation as a monk?

How did he manage to do all this, why did he do it, and what led him to do it, given that he was a monk?

Abbot Hildebrand was certainly a monk in the real sense of the term, a monk without compromises. If the motto of the Benedictine monks is "*Ora et Labora,*" he certainly embodied that motto with distinction. He was a man of prayer, and how much he prayed! Those who accompanied him on his journeys can bear witness to the fact that the car became a chapel and an office. He often passed long hours during the night deep in prayer, in front of the Holy Sacrament, at times literally prostrate on the floor.

There, in the silence of the night, he opened his heart to the Lord; from the Lord he received the strength to go on; and in his love for God he felt his compassion and love for his suffering brothers grow within him. It was during the war that he became especially devoted to the Holy Face of Jesus Christ, a devotion which had been dear to many

Benedictine saints and mystics, both men and women, in times past. Through his intense and constant union with Christ the Redeemer he saw the suffering Holy Face in the face of his brethren in need. This was the force which moved him. This was the spring from which he drank and which gave him the energy for his prodigious activity. His "*Labora,"* his work, was the fruit of the first part of the Benedictine tandem "*ora"* which he certainly lived out with impassioned intensity.

4. A Man for Others

With regard to the second part of the tandem, the *Labora,* nobody ever saw him at rest or on holiday. From the period when he was a young monk full of fervor he had resolved to never lose a minute of time, and this was a promise he kept until the end. And he spent all his time working for others—his fellow monks, his boys and girls, his spiritual daughters, and all those who came to him in search of material and spiritual help. He loved painting, music, and poetry, but once had finished his studies he had to leave his personal tastes to one side in order to dedicate himself to others.

Can one say therefore that this kind of life was "nonmonastic"? The ancient Fathers of monasticism, namely Pacomius, Basil the Great, Martin of Tours, have welcomed Abbot Hildebrand into their midst with joy, as they welcomed those who contributed to the construction of Christian Europe.

Who does not know that in the past the monasteries had wonderful cures and medicines? (Cf. *The Name of the Rose* by Umberto Eco!). St. Benedict, after all, in the fourth chapter of his Rule calls upon the monks to "help the poor, dress the naked, visit the sick, bury the dead, to go and help the suffering, and console the afflicted." Amongst the precepts which the Rule lays emphasis upon with especial force is that of caring for the sick ("care for the sick must be more important than anything else, and they must be served as one would serve Christ") and caring for the elderly and for children ("although human nature itself is inclined to be compassionate towards the old and towards children, it is right that the authority of the Rule should provide for them").

A monk and a Good Samaritan—this is what gives Abbot Gregory, the Servant of God, full right to citizenship of this conference and justifies the inclusion of his name amongst the Good Samaritans of our time, those figures which we are commemorating here today. As a monk, as a contemplative, as a mystic, Abbot Hildebrand invites us to the spring of our ideal and our

strength: the contemplation within the suffering Christ-God of those who are in need and in pain.

5. The Man of Vision

Abbot Hildebrand was a man of vision: he described his vocation to religious life as an unforgettable experience and vision. During the First World War, on the fields of battle, he had the vision of what it would be necessary to do for children after the conflict was over. When he first saw the ruined place where he would have to set in motion his great work of charity, he had a vision of what it would indeed become.

When after the trials and tribulations of the war, society finally took shape again and moved towards well-being, the new generations no longer needed that kind of help. Abbot Hildebrand, who was by now free of the weight of the office of superior general, directed his thoughts to a new category of people who were falling into the hands of thieves—the elderly who had been discharged from hospital and who were often without homes and without people who wanted or were able to take care of them. Abbot Hildebrand began to take care of these new "poor," and upon their wounds there flowed the oil of his charity. The Servant of God predicted what was about to happen and foresaw what had to be done about it. He thus gradually begun to transform the buildings which he had built for children and to create structures which were suitable for elderly people, and especially for the bedridden. At the same time he ensured that many of his nuns became qualified as nurses and were thus ready to deal with the new situation. He tried to inculcate within them a great love for the weak and the needy, and this because what elderly people have most need of today is love and understanding.

6. Atonement

One of the typical qualities of Abbot Hildebrand was always that of taking objects which had been thrown away or deemed too old, including dilapidated properties and buildings, or broken or valueless artistic works, and restoring them or bringing them back to their original condition. What he managed to do with extraordinary success with things he was able to do in even more admirable fashion with people. The thin faces of children became healthy and radiant once again and the sad expressions of the elderly once again became serene and smiling.

The austere monk also became transformed when he was amongst his children and his elderly folk. He laughed, joked and was happy at the parties and entertainment he organized for them. He gave the name of

"Sisters for Reparation to the Holy Face of Jesus" to the religious congregation he established. This name has too often been understood as referring to a mere devotional element: prayer and penitence in atonement for the injuries done to the Lord. For the Servant of God, however, the name had a broader and deeper significance: atoning for, and restoring, the Face of Christ, a face which had been disfigured by human weakness and ingratitude; living up to His commandment to love; and commitment to the renewal of the bodies and the souls of those of our brethren who are weakest and most in need.

7. His Message

The message of Abbot Hildebrand, through his work, his words and his devotion to Holy Face of the Lord, is thus a message of love and of hope. Just as the disfigured Face of Christ can once again be splendid and glorious in our Lord's Resurrection, so the suffering faces of children and the poor can once again be radiant with love and hope.

"Our program—he once said to His Eminence and to his nuns my program, your program, the program of the nuns, is to do good, to do good, to do a great deal of good, the good of souls and bodies." In another improvised speech to the nurses and doctors of the Lateran Hospital of St. John, in Rome, where his nuns were students, the Servant of God left the following message:

"The most valuable part of the human redemption has been entrusted to you: that of the 'least' of Jesus Christ,

the poor and the elderly,

the man afflicted by cancer,

those struck down by every other illness....

The young woman who bears the weight of guilt in addition to her physical torment turns to you,

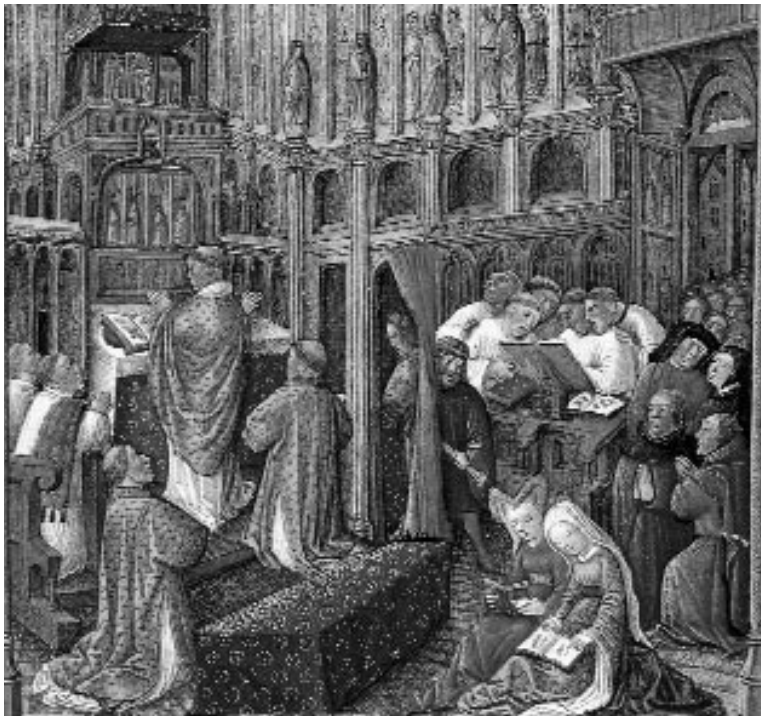
the child whose suffering makes him cry and call for his mother, the child who perhaps does not have a mother, turns to you.

Dear teachers, thank God who has placed in your hands the most blessed of all arts—that of drying tears. May the God Lord, dear doctors, help you to dry many tears. May your service be a real service to souls and to bodies."

When reflecting on the parable of the Good Samaritan, I like to see Abbot Hildebrand as another person of the parable, namely the innkeeper. We are not told that he himself went to the wounded man—on the contrary, the wounded man was brought by the Good Samaritan and entrusted to the innkeeper. Yet the innkeeper was certain that his Friend and Lord would have returned and would have repaid him handsomely for what he had done. Many of us are in the same situation—the poor and the needy in soul and in spirit are entrusted to us by the Good Samaritan on different occasions during our lives.

He has given us a great deal to be spent in caring for His Last, those whom he loves the most, and we can be certain that He will reward us, and in great measure, on His Return. In the same way as He did with his faithful inn-keeper, the Servant of God—Hildebrand.

Abbot SIMONE TONINI
Postulator of the Cause for the Canonization of the Servant of God



JANUSZ BOLONEK

Dr. Janusz Korczak

I would like to introduce Janusz Korczak, one of the great men of Poland: doctor, writer and educator. Born in 1878 or 1879 in Warsaw, he died fifty-three years ago and was probably killed in the Nazi extermination camp of Treblinka in August 1942 (so far nobody has been able to establish with certainty the dates of his birth and of his death).

Janusz Korczak is the assumed name of Henryk Goldszmit. This name was taken from the title of a novel by Jozef Ignacy Kraszewski: *Historia o Janaszu i o Pieknej Miecznikownie* ("History of Janusz Korczak and the Beautiful Daughter of the Sword-Maker)."

Doctor Goldszmit did not have a striking appearance and was not very tall. He was bald and had a red beard. Throughout his life he had a soft and thoughtful countenance and he was always noted for a by no means commons nobility of heart and beauty of spirit. He never adhered to a political party and was never a Communist or a freemason.

He was a modest and hard-working man who throughout his life walked on the path of truth, which he constantly looked for, and of deep responsibility. He was constantly engaged in silent and complete selfless service to those most in need. He dedicated his entire life to the children of other people. As a skilled medical doctor and an accomplished teacher he loved children with his whole heart, with his whole mind, and strove to the utmost to achieve their full development and growth. He gave himself unreservedly to the cause of children.

As a writer and freelance journalist he brought out and described the whole range of human poverty and misery, and also drew attention to the elementary needs of the poorest social strata. He also encouraged people to fight against evil and to do good; believed in the existence of universal moral rules and guidelines; and struggled to uphold and defend the rights of man, especially those of poor and abandoned children. He wanted and strove to organize the society of children in harmony with the principles of justice, fraternity and the equality of rights and duties.

Janusz Korczak now appears as a exemplary model for how man should treat his fellow man. The strength and influence of what he did has grown and spread throughout nearly the whole world. The story of his life, his work and his teaching activity have reached and come to the attention of an ever greater number and breadth of founders and exponents of ideologies, of religious creeds, of races and of continents.

In many countries associations exist which take their names from Doctor Janusz Korczak, and these associations have existed for a long time. His writings have been and are published in a large number of languages. International conferences discuss his life's work and research centers have sprung up which are dedicated to studying his initiatives and activities. The figure and the life of this extraordinary doctor and teacher, and in particular his heroic death and that of his pupils, inspire musical and literary works, films and song, radio programs and television broadcasts. From June 1978 until September 1979 UNESCO celebrated the centenary anniversary of the birth of this great humanist by organizing suitable ceremonies to celebrate and commemorate what Korczak did during his life.

But who was Henryk Goldszmit alias Janusz Korczak, and what did he do?

Henryk Goldszmit was born on 22 July 1878 or 1879 in Warsaw, a city which at that time was under Russian occupation. He was the son of a famous and wealthy lawyer, Josef Goldszmit, and of Cecylia Gembicka. The families of both his parents were of Jewish origins and although they were fully assimilated into Polish culture they were not Christian. Whilst on the one hand the Catholics and the National Block could not forgive Korczak his Jewish origins —indeed they used to say of him that although he was a good man he was also a Jew —the Jews for their part rebuked and admonished him for his having become Polish and for his full assimilation into Polish culture and customs. Henryk Goldszmit did not actually know Yiddish or Hebrew. The formation of his personality was strongly influenced by the works of two eminent and distinguished Polish writers: Stefan Zeromski (1864-1925) and Boleslaw Prus (1847-1912).

Korczak was a talented and sensitive boy who was rather shy and silent. He spent his childhood in conditions of prosperity until the serious illness and then death of his father. The years which followed — the years of school and of university —were difficult years because Korczak had to look after his mother and his sister.

After finishing the Russian philological school he wanted to engage in solid learning and study. He chose the discipline of medicine at the University of Warsaw and went to the faculty of pediatrics. He chose to study the medicine of children "because in addition to the vice of thinking I also still had a heart."[1] This heart of his was tender in its attitude towards poverty and suffering, especially when abandoned, ne-

glected and distressed children were involved. His heart led him to concern himself with the condition of the children of the beggars of the poor Warsaw district of Powisle, children with whom he used to go and play and to whom he gave lessons. These children became the subject of his first novel which was entitled "Dzieci Ulicy" ("Street Children") and which was published in 1901.[2] The book, which was in truth perhaps a little naive and immature, described the lives and conditions of homeless orphans in the city and narrated their dramatic attempts to survive in these harsh circumstances. It should be immediately observed that Korczak placed his talent as a writer first and foremost at the service of the less socially fortunate children, and to such children would he subsequently devote a large number of novels.

He finished his medical training at Berlin, at Paris and at London. He returned to Warsaw in 1903 and began to work at the Berson and Bauman children's hospital in Sliska street. At the same time he wrote critical articles on social questions for such reviews as *Glos* and *Kolce*. He also published a collection of humorous short stories entitled *Koszalki Opalki* ("Nonsense and Tall Stories") (1905) and a second novel: *Dziecko Salonu* ("Son of the Salon") in 1906. The novel is based upon the protest and the rebellion of a son of the bourgeoisie against the capitalist environment and milieu of his parents and also describes his tragic fate and destiny.[3]

In 1905 Korczak was called to arms in the Russian army and was sent to the front of the Russo-Japanese war which had broken out that same year. For more than six months he was the senior doctor on the hospital trains which transported troops which had been seriously wounded or were gravely ill. He reached as far east as Lontan in Manchuria. He then worked at the evacuation centers of Harbin and Toataj-Dzou.[4]

During the First World War he was called up as a doctor and became vice-director of a military hospital on the Ukrainian front. After this position he worked in a center for children in the Ukraine in the Kiev area and for a short while he was posted to a Polish boys institution. Here he continued to evolve and develop his ideas and theories about the education and upbringing of children.

In 1918 he returned to Warsaw in order to become the new head of an institute for Jewish orphans. For a short period he worked at the Lodz hospital for infectious diseases which looked after dysentery victims and he then spent some time working in the same kind of hospital at Kamionek in the Warsaw region.

He was keenly sensitive to the dilemma represented by the two rival concepts of *medicina aurea* and *medicina pauperum*. He earned high fees treating the children of the rich but he treated the poor for nothing

and at times also gave them money to buy the medicine which he had prescribed. He asked a mere token payment from poor Jews given that the Talmud declares that: "A free doctor does not help the sick." His generosity provoked the envy and hostility of many of his colleagues who saw him as a corrupter of patients and even went so far as to think he was mad! Indeed, the most malicious and vindictive of his colleagues did not hesitate to send him patients during the period of night rest.

However, people on the so-called social margins found in him a great and magnificent soul which was very sensitive to the needs of his neighbor. He was particularly kind and caring towards sick and weak children. He became an authentic Good Samaritan for orphans. With his smile and his dedication Korczak had a disarming effect on those with hard and severe hearts and unlocked within them feelings of pity, compassion and help towards poor children and young people.

After seven years of work and service as a medical doctor he gave up pediatrics and chose teaching instead. He became an educator of orphans. He wanted above all else to serve poor and neglected children. In order to dedicate himself completely to his mission he decided not to have a family himself: "I remember the moment when I decided not to have my own family. It was in a park in London...I chose as my child the idea of serving children and their cause."[5]

He loved children with great affection and he dedicated himself to their well-being without reserve. He wanted to help them and to promote their development from a physical, intellectual and moral point of view. He was both a doctor and a nurse for them, but above everything else he sought to be their father.

He also organized an intense social activity in the free reading rooms of the Warsaw Charity Organization and Association of Summer Camps. He went as an educator to the summer camps of Michalowka and of the villa Rozyczka of Goclawek near Warsaw. There he took care of weak and frail children whether Jews, as in 1907, or Christians, as in 1908. Two books for children were also the outcome of this summer work —*Joski, Moski i Srule* (1910) and *Jozki, Jaski i Franki* (1911). Korczak tried to overcome and to break down the mutual prejudices and antipathies which prevailed between Jewish and Polish children. His educational work and endeavors were not confined to a narrow sphere of racial separatism but rose above the national and religious antagonisms of the time.

He also took part in the activities of the Polish Association for the Defense of the Child. He felt solidarity with the Jewish section of the population and thus felt especial concern for the orphans of the Jewish proletariat. He was one of the organizers of an institute in Franciszkanska Street in Warsaw. In 1912 the Home for Orphans transferred to its new site at n. 92 Krochmalna Street and Korczak became its director. In his educational work he was helped in very valuable fashion by a Jewish woman named Stefania Wilczynska. Today there is an institution for chil-

dren in this street, an institution which bears the name of Doctor Janusz Korczak.

A few years later, in 1919, Korczak set up another orphanage for the children of Polish workers. This orphanage bore the name of "Our Home," and it was created with the help of another woman, Maria Rogowska Falska. It was established at Pruszkow in the Warsaw area. Later this institute was transferred to Warsaw in the Bielany district.

These two homes were principally for children between the ages of seven and fourteen.

Korczak was a teacher at the State Institute of Special Teaching and at the Free Polish University of Warsaw. He also wrote a great deal, chiefly about teaching and teaching methods. As early as 1913 he had published *Slawa* ("Glory"), a work full of lyricism and humor which was a study of the psychology of proletarian children. Two years later Korczak published Bobo (1914) — "some short novels about wrongs done to children whose minds are described with great insight"[6].

During the First World War, whilst at the front, Korczak wrote a two-volume book on education and upbringing entitled: *Jak Kochak Dziecko* ("How to Love a Child") (the first volume was published in 1920, and the second, in 1921 and 1929). In the years 1919-1926 he published a series of articles, as well as other articles, in a journal for children and young people called *W Sloncu* ("In the Sun"). These articles went under the heading of *Co Sie Dzieje W Swiecie?* ("What's Going on in the World?"). He also wrote the introduction to a study by Jedrzej Sniadecki entitled *Rozprawa o Fizycznym Wychowaniu Dzieci* ("Dissertation on the Physical Education of Children") (1922) and a small book with the title *O Gazetce Szkolnej* ("School Journalism") (1921). The titles of his next books were equally eloquent: *Sam na Sam z Bogiem. Modlitwy Ludzi, Ktorzy Sie Modla* (A Tete à Tete with God. Prayers of Those Who Do Not Pray") (1922); *Krol Macius Pierwszy* ("King Macius I"); and *Krol Macius na Bezludnej Wyspie* ("King Macius on a Desert Island") (1923), a novel about a child drawn into the difficulties of the lives of adults and about the responsibilities of the individual towards the nation.

Korczak also published the novel *Bankructwo Malego Dzeka* ("The Bankruptcy of Little Jack") (1924), which promoted (and argued in favor of) the cooperative movement. There also followed the story "Kiedy Znow Bede Maly" ("When I Am Little Again") (1925), a tale of a man who returned to the world of childhood; "Bezwstydnie Krotkie" ("Unashamedly Short") (1926), dialogues on the freemasons and the Jews; a small published program under the heading "Prawo Dziecka do Szacunku" ("The Right of the Child to Respect") (1929); and *Prawidla Zycia. Pedagogika dla Mlodziezy i Doroslych* ("Rule for Life. Teaching Methods for Young People and for Adults"), which appeared in 1930.

The Atheneum theater of Warsaw put on a play written by Korczak entitled *Senat Szalencow. Humoreska Ponura* ("The Senate of Madmen. A Dark Humorous Tale" (1930), which describes the increasing madness of the world. Korczak also published a number of children's stories for the series *Biblioteczka Palestynska dla Dzieci* ("The Little Palestinian Library for Children") which were intended for both children and adults: "Ludzie sa Dobrzy" ("Men are Good") (1938); "Trzy Wyprawy Herszka" ("The Three Expeditions of Herszek") (1939); and "Refleksje" ("Reflections") (1938).

It should also be recorded that in the years 1926-1931 Korczak directed (together with a number of children) the periodical review for children and young people *Maly Przeglad* ("The Little Review"). This review was a supplement to the Jewish publication *Przeglad* ("The Review").

Korczak also served children through the radio. In the years 1935-1936 he held a series of talks on teaching on Polish Radio which went under the title of "Gadaninki Radiowe Starego Doktora" ("Radio Story-Telling by an Old Doctor") and which were listened to eagerly by adults and children alike[7]. These radio tales were published in 1939 under the title *Pedagogika Zartobliwa* ("Humorous Teaching").

Korczak amazed people with his extraordinary gift of being able to establish direct contact with children and young people, a contact marked by full understanding. He educated thousands of Jewish and Polish children and ensured that they became worthy adults.

His teaching and teaching methods were full of medical science. He also drew upon the experiences of a famous Swiss educator and writer called Johan Heinrich Pestalozzi (1746-1827) and upon some of the ideas of the great Russian writer Lev Tolstoy (1828-1910), who advised adults to learn from their children.

In essential terms, the teachings and teaching methods of Korczak were based upon dialogue with children—that is, upon a dialogue between pupil and teacher. This dialogue rested upon a love rooted in the inner conviction that only that which is lived can be really transmitted to the child. This "teaching of wise love" (*Natalia Hanilgiewicz*), which is also called "teaching of the heart" (*Danuta Solowicka*), centers upon respect and love for the young person, who is not considered a virtual man but a man in the full sense of the term. The society of children formed by Korczak was directed towards self-education: it had its own self-government (the parliament of children and the council of self-administration) and a jury of honor. Janusz Korczak was able to create and establish a model of universal solidarity among children.

When faced with the social conflicts which were becoming more acute at that time, and more specifically the increasing separatism between Pole and Jew, and when confronted with ever greater economic difficulties (the struggle for the very existence and the feeding and maintenance of the "Home for Orphans"), Korczak at times felt disappointed and discouraged. He even thought of moving to Palestine where he went for brief periods in the years 1934 and 1936. He then began to write upon mystical subjects and upon the bible. He wanted in particular to write a work which praised the work of the "chalucim" or pioneers. The project of a final and definitive departure from Poland, however, never came about, and this was because Korczak "was too linked to the Polish language, to Polish culture, and to Polish children."[8]

During the years of the Second World War, whilst Poland suffered terribly under the Nazi occupation, Korczak organized and defended the lives of the children who had been entrusted to his care, and he managed to do this under very severe and difficult conditions. He defended them from hunger and from attacks. Under the bombs and under the artillery bombardment he ran up and down the streets of Warsaw.

Every day he challenged death itself and went on long journeys from Krachmalna Street to the center of the city. He found lost children in the streets, children who were frightened and often wounded. He carried them to shelters and to clinics and provided them with food and with clothes. He knocked at the doors of private houses and of social institutions and asked for food for those protected by his "Home for Orphans."

In the autumn of 1940 this home was transferred to the Jewish ghetto. Wearing the uniform of a major in the Polish army on the day of the removal, Korczak was arrested for not having the required yellow star of David sewn onto his sleeve. For a few months he was interned in the Pawiak prison. Released on bail by three of his ex-pupils, and by now over sixty years of age, he continued to take care of his pupils and children. In addition, the city authorities entrusted him with the directorship of a municipal help center which was situated at number 39 Dzielna Street. The *Pamietnik* ("Diary"), which was written in 1942, is an eloquent document of this last and dramatic period of the life of the "Elderly Doctor" which was spent in the terrible conditions of the ghetto. There also he dreamt of a great orphanage below the Lebanon where every night through the sky-light he could watch the stars of the Palestinian sky. The "Diary" has survived because it was walled up in "Our Home" in Bielany.

Through the many trials and tribulations that Korczak underwent during his life and as a doctor, he never lost his faith in God. This is borne out by many elements, not least by the book which has already been mentioned: "A Tete à Tete with God. Prayers for Those Who Do Not Pray." This work is a chorus of voices which beseech. At times they are full of laments and of protests, but more often they speak of love and of gratitude. These prayers reflect the state of mind of people of various ages who have a broad range of jobs and social positions. A profound and creative faith was certainly the inspiring force of his service to his neighbor, a service full of devotion. At the same time it was the shortest path by which he walked towards God, even though this path was neither easy nor full of joy.

For the whole of his life Korczak sought God. Although he did not belong to any one religious faith or denomination, he felt a special sympathy for Judaism and for Christianity. Yes, indeed! He was known for a positive attitude towards Christianity, which was demonstrated by an acceptance of certain principles and certain truths of the Christian faith. In "Our Home" at Bielany he decided to create a chapel for the Catholic children and in the "Home for Orphans" in Krochmalna Street he constructed a house of prayer for Jewish children. He also formulated and elaborated many thoughts on education which conformed to the spirit of Christianity. In his attitude towards life one can detect a strong tendency towards a spirit of ecumenism which was expressed in a commitment which was full of dedication to both Jewish and Polish children.

Like a good shepherd he gave his life for the cause of children. He died at the beginning of August 1942. He was murdered at the German extermination camp of Treblinka in Podlasie in the valley of the river Bug. The Nazis killed about 750,000 people in that place, and these were chiefly Jews and people of Jewish origin. Korczak did not want to take advantage of the possibility of saving his own life but he freely decided to accompany two-hundred children on the journey to the Shoah. An order was issued in the ghetto to take away the Jewish children and this meant inevitably that they would be taken to the gas chambers given that the Nazis gave the Jews "the right of precedence" for the gas chambers in the German extermination camps.

The "Home for Orphans," with its educators and pupils, was forced to empty during the first days of August. "Then Korczak led his children for the last time down the streets of Warsaw towards the so-called "Umschlagplatz" (the railway junction in Stawki Street) where the Jews were loaded for transportation. It seems that at the last moment it was proposed that he should receive a personal reprieve, but this suggestion was refused by Korczak. Until the very last moment he continued to calm his children by telling them they were going on a trip to the countryside, and with them he went to meet his death"[9]. He remained faithful to the children who had been entrusted to him until that moment when he met with his own "holocaust."

Janusz Korczak, however, was not a man of a single important action. His last action was a conclusion which was consistent with what he had done previously in his life. It is not possible to understand this heroic action without recognizing his great fatherly heart, which wanted to be near to children, especially when they were in danger. This action cannot be really understood at its roots without reference to the adherence to the moral principles which as a medical doctor and a teacher he professed, animated as he was by a deep and spontaneous religious faith. Through his heroic death he expressed and confirmed the mission of his life. If he had been a Catholic, he would have been proclaimed a saint and would certainly have reached the glory of the altars.

The "Samaritan for children" is dear to our times, especially when we realize that there are today millions of abandoned, hungry, demoralized, and illiterate children who are deprived of their basic human rights, the "children of the streets" who live on all the continents of the world. Korczak can and should be an example and an inspiration for all those who strive and work for the good of "the least of my brethren" (cf. Mt 25:40-45). Korczak attributes to these "least" a decisive role in achieving the spiritual rebirth of mankind.

Most Rev. JANUSZ BOLONEK
Titular Archbishop of Madauro,
Papal Nuncio in Romania

Notes

[1] I. NEVERLY, introduction to and commentary on: Janusz Korczak, *Wybor Pism*, (Writings), vol. I-IV, (Warsaw, 1957-1958).

[2] H. MORTKOWICZ-OLCZAKOWA, "Goldszmit Henryk,"in *Polski Slownik Biograficzny*, (Polish Biographical Dictionary), vol. 8, p. 214.

[3] *Ibid.*

[4] Cf the articles by Korczak published in "Glos" in December 1905 and the results of the studies carried out by Kinga Sienkiewicz using the documents kept by the Russian Central State Archive of Military History in Moscow.

[5] Letter from Korczak to Mieczyslaw Zylbertal dated 30 March 1937.

[6] H. Mortkowicz-Olczakowa, *art. cit.*, p. 214.

[7] See J. PIOTROWSKI, *Ojciec Cudzych Dzieci. Wspomnieni o "Starym Doktorze" Januszu Korczaku*, (Father of Other People's Children. Memories of the "Elderly Doctor" Janusz Korczak), (Lodz, 1946).

[8] H. MORTKOWICZ-OLCZAKOWA, *art. cit.*, p. 215.

[9] *Ibidem.*

*Translator's note: All spellings from the Polish have been Anglicized. They thus diverge from the Polish alphabet.

VINKO PULJIC

Pastoral Medicine in Bosnia and Herzegovina During the State of War, with Special Reference to Sarajevo, the Concentration Camp City

At the beginning of this paper I would like to extend a cordial greeting to each of those who are present here today at this important meeting. I would to thank in particular His Eminence Cardinal Fiorenzo Angelini for his invitation to me to relate some of the key experiences of this war.

Introduction

I would like to describe to you the land and the city I come from. Bosnia and Herzogovina is a state which was formally recognized as such by the United Nations in 1992. It covers five thousand, one hundred and twenty-nine square kilometers. According to the census of 1991 it had 4,365,600 inhabitants, of whom 43% (forty-three per cent) were Muslims (who during the war came to call themselves Bosnians), 31% (thirty-one percent) were orthodox Serbs, and 18% (eighteen per cent) were Catholic Croats. The rest belonged to small minorities or were simply Yugoslavians.

In this state there are four Catholic dioceses with three episcopal seats: Sarajevo, the seat of the archbishop and metropolitan, Banjaluka, Mostar, and Trebinje which is an apostolic administration entrusted to the bishop of Mostar. The capital is Sarajevo, a city which before the outbreak of this war had about 550,000 (five hundred and fifty) inhabitants. This city reflects the variety of religions, cultures and nationalities which are present in Bosnia and Herzegovina.

1. The War

In 1991 the ex-army of the Yugoslavian Federation was already clearly displaying its intention of occupying Bosnia and Herzegovina in order to achieve its project of a Greater Serbia. The aggression had already begun in September 1991 with the destruction and the ethnic cleansing of the Catholic areas of the west of Herzegovina where there is the diocese of Trebinje. The entire war arsenal which had been withdrawn from Slovenia and Croatia was placed strategically in Bosnia and Herzegovina. This war was planned and launched as a result of policy formulated by Belgrade and had the aim of conquering new territories for a Greater Serbia which would be nationally homogeneous. The barbarity of this war was displayed in particular in the case of Belgrade.

At the beginning of April 1992 there begun a series of tragic events and the systematic destruction of Sarajevo. At the beginning of the war operations the Serbian Orthodox Church moved its center outside Sarajevo and most of the orthodox priests abandoned the city before the outbreak of the war. All this was in line with a pre-established plan, as if it was already known what fate awaited Sarajevo.

When the city was hit by heavy bombardments and mortar fire it was a real miracle that the people of Sarajevo were able to organize themselves and defend themselves without arms, and then to survive the siege. At the outset people believed that the attack would not last long and that the madness of the aggressors would not go on for long. Unfortunately, the explosions continued inexorably day after day, followed by fires and destruction. There were very many wounded and dead people in the streets and in the houses. The city authorities were not prepared for war and for this reason they were taken by surprise. Indeed, no provision had been made even for essential reserves of food or other essential supplies. Furthermore, no arms had been stockpiled and there was no overall plan for the defense of the city.

In addition to the total blockade of the city and about 600 places of firepower made up of heavy artillery and tanks placed on the mountains around Sarajevo and pointed towards the defenseless city, the military strategy of the Serb aggressor included other measures—the cutting of the water, gas and electricity supplies, the destruction of the telecommunications system, the obstruction of free entrance and exit from the city, the killing and wounding of the largest number of people possible by merciless snipers, and the systematic destruction of anything which could be useful to the inhabitants. For this reason food and medicines in the city began to fall into short supply, and this situation lasted for about four years. Military specialists say that millions of shells exploded in this city.

2. The Consequences of the Destruction Caused by the War

1) The impact of the horrors of the war. The first consequence was the disorientation of the organization of people's lives and activity. The destruction of the communications system isolated and distanced people from their neighbors even in physical terms. In particular, the destruction of the telephone system created great uncertainty about what had happened to friends and neighbors, and naturally enough it was impossible for people to communicate with them and thus help them.

2) Fear caused by the terrifying

explosions. There were days when shells exploded constantly without interruption almost every minute or second. This led to a very worrying question being asked: who has been killed and what has been destroyed?

3) Horror caused by the numbers of dead and by the massacres. People forced to venture out to look for a piece of bread, water or other primary necessities, often fell victim to the explosions in the streets and many people lost their lives in their homes—those homes being specific targets for destruction.

4) The burying of the dead. There were days when it was impossible to carry the corpses from the streets because of the terrible bombardment. At the same time, the cemeteries were in the line of fire and thus could not be used. As a result, the corpses were often buried in parks or in places hidden from the snipers. In such circumstances, naturally enough, there was a complete absence of those decencies which are present when there are funerals in the civilized world. In this war about 12,000 people were killed in the streets of Sarajevo, and about 1,500 of these were children.

5) Care for the wounded. It is estimated that about 50,000 people were wounded at Sarajevo over the whole of this period. There were various kinds of wounds from the loss of nether limbs (in particular hands and feet) to total paralysis and loss of physical autonomy and the consequent need to depend totally on other people. An especially serious trauma is that experienced by wounded children who will have to remain handicapped for the rest of their lives.

6) The lack of essential foodstuffs. The few reserves of foodstuffs and other vital necessities were soon used up. Humanitarian aid arrived in small quantities, and the food which was given was too uniform in character and did not have the elements necessary to allow the human organism to engage in normal work.

7) The consequences of a lack of energy sources. The disappearance of electricity and gas—elements which are vital to heating and cooking—caused very great hardship to the people. During the first winter of the siege all of the trees in the city were soon cut down to provide heating and fuel for cooking.

8) The lack of water was another very great problem. Water is necessary not only for cooking but also for the most basic hygienic needs. It is also vital for drinking and providing liquid for the human body. At the outset there was also the fear that the little water which was obtained at the risk to people's lives might perhaps have been poisoned. Personal hygiene and hygiene more generally could not be looked after because of the acute water shortage.

9) The impossibility of maintaining personal hygiene and hygiene more generally. The water reserves were soon exhausted and what little arrived through humanitarian aid was completely inadequate for such a large number of inhabitants. The

lack of water made it impossible to maintain hygienic standards at a personal level and in the work place. In the sewers dangerous insects, mice and rats began to proliferate and to infest the sewer system and people's houses. Mountains of garbage and rubbish accumulated in the streets because it was impossible to move it to the public dumps. All this greatly compromised the health and hygiene situation in the city.

10) Various kinds of psychic traumas. Because people were forced to pass days and nights in cramped, dark and damp places, often in total darkness, the "basement syndrome" made itself felt, and this particularly affected children, with obvious very serious consequences for their mental health. The large number of nights spent in this way by the adults caused various kinds of neurosis, principally because of uncertainty about what would happen the next day and because of the fear of impending hunger—this afflicted nearly everybody after the food reserves had run out. The parents in particular suffered because they were not able to satisfy the most elementary needs of their children. Different kinds of depression also had their impact and provoked nighttime anxiety rooted in the presence of the spilling of so much blood and the massacres. Such traumas were present first and foremost in the elderly and the weak—people who feel themselves alone and abandoned. The same may be said of children whose parents were killed or severely wounded and handicapped. To all this must be added the interior anxiety caused by uncertainty and worry about loved ones of whom nothing is known.

11) Relationships with loved ones interrupted. The war broke lines of communication between the members of families, between husbands and wives, between parents and children, and between friends and acquaintances. Some were enrolled and sent to the front, others disappeared and yet others made sure that their whereabouts were not known. Deep wounds were been caused to personal relationships, wounds made worse by fears and complete uncertainty.

3. The Bringing of Light into the Darkness of War

The Catholic Church, amidst all these horrors of war, sought to organize itself so as to provide every kind of help possible to people who found themselves in the difficult situation of war and pressed by so many trials. In order to achieve these aims the Church took a broad range of steps and engaged in a variety of initiatives:

1) In the first place priests and members of religious orders (both men and women), led by their bishops, remained next to the people and encouraged and supported them with their presence so as to enable the inhabitants to bear all these privations caused by the war.

2) Despite the dangers of the war, the church assembled its faithful to pray and to celebrate the Eucharist in order to create the sense and feeling of a community. This played a very important role in overcoming a sense of loneliness and of being abandoned. In this communion of faith a nearness to God and one's fellow

men was felt. In these meetings of faith the dialogue with God and between men meant that people slowly managed to reduce the tension they felt and to draw upon the spiritual energy which was necessary to the overcoming of their difficulties. An especial source of spiritual energy in this process was personal and community prayer, participation in the sacraments and in particular the word of God, reconciliation and communion. Being fully aware of this, I strove to visit each community of the faithful as much as possible and to encourage both priests and the faithful with the word of God. It was evident that after each meeting of this kind, and after the celebration of mass, people were able, so to speak, to radiate from their eyes rays of light, and they thus returned renewed to their homes.

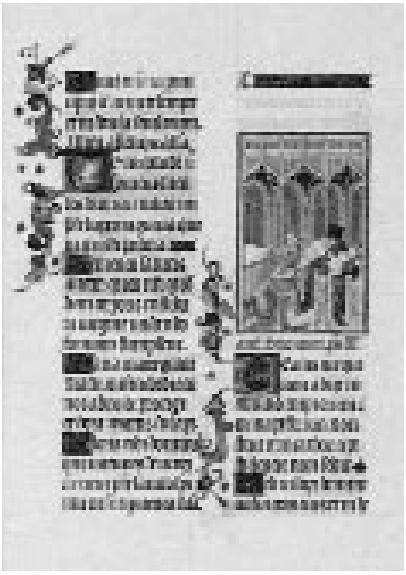
3) The organization of humanitarian help through Caritas. Although there was a break in the systems of communications with the outside world, we made effective efforts to find other ways of bringing aid to Sarajevo and distributed it to the inhabitants so as to ensure their survival. In addition to bringing food, we also organized the arrival of medicines, having provided to those who helped us with a list of medicines and health needs that we required. Some of this was distributed to the civilian hospitals and the rest was given to pharmacies organized by Caritas and brought near to the people throughout the city so that they would not have to expose themselves to the dangers of the streets. In the streets there was no public transport and snipers were constantly at work.

Through Caritas we organized the presence of doctors in parish centers and in other suitable structures. To this end we opened the medical center of St. Vincent in the center of the city where we organized a pharmacy, a clinic and a surgery. In this center we also set up a kitchen which was programmed to produce a hot meal for thousands of people. In special fashion an attempt was made to help women in their special difficulties, trying to give them advice with regard to the problems that faced them and their dilemmas of conscience.

4) Help to the aged. Seeing that an ever increasing number of elderly people remained in the houses, and that these people were often ill and in need of help, we organized a help system which involved regular visits to these elderly people and brought them medicines and humanitarian succor. Such activity was carried out above all else by female members of religious orders.

5) The purchase of heating stoves and their installation, especially in the homes of the elderly and the sick. Here we are talking about a kind of stove which is able to burn almost every kind of combustible source of energy. When gas became available we helped many people to install it in their homes.

6) The renewal of interrupted relationships. I, like so many male and female members of religious orders and priests, could enter and leave the city—and at great risk to our lives. We could thus act as postmen and deliver letters and parcels of medicines and food. Caritas also did this. Often this was the only way to ensure that people received news about their friends and relations and obtained help in terms of money.



Through our vicariate at Zagabria we also organized a service for providing financial assistance to people. The system worked as follows: people deposited a certain sum for their relatives in Sarajevo with our vicariate and our archdiocese paid that sum directly to the recipients in Sarajevo through Caritas. This was a subsidiary banking service—the only one that worked—and naturally enough involved no attempt at gain. During the most difficult and serious periods of the war it was often the only means by which to ensure a minimum level of survival to the people besieged in Sarajevo.

7) The activity of the mass media. We organized an information service through a private radio system of the diocese and the distribution of newsletters of various kinds in order to counter and combat the other forms of mass media which were involved in the systematic propagation of the poison of hate towards others and intolerance towards others. We also sought to build a culture of love and of life through radio broadcasts on fundamental human values and through the transmission of the holy mass and of the word of God. We tried to communicate a little optimism to people through our radio station “Vrhbosna” (which is the historic name of the diocese of Sarajevo when the city had not yet come into existence in the medieval period) and through the publication of various books and leaflets with which we tried to break the stranglehold on news and to combat one-sided information.

8) Cultural activity. We organized meetings of young people through the Church and through the Croatian cultural association “Napredak” (Progress) in order to combat the climate of barbarity which the war had installed and also to instill the values of peace in young people. Our intention was to have a series of cultural demonstrations and events in the midst of the roar of war in order to give a clear signal to the city and to the whole world.

9) The opening of a Catholic school center where we established a primary school, a secondary school and a medical school. In this way we were able to able to give students a real future amidst the heavy and imposing war atmosphere and the climate of hatred and fanaticism. Lessons could be attended regularly and students could hear arguments and ideas which expressed the positive values of reconciliation, tolerance and peaceful coexistence. Esteemed listeners! I have sought to show you through these brief descriptive flashes how our people in Bosnia and Herzegovina have had to endure heavy suffering. Their lives have been deeply disturbed by the war, and this is especially true in the capital city Sarajevo, a city which has been besieged and transformed into a concentration camp. I have also tried to show you what the Catholic Church has done and is doing to help these people in their trials

and tribulations. Just as the pain and the suffering of each individual cannot be described, so is it impossible to describe even superficially what has been done for this poor people—the care, concern, help and assistance provided by priests and the members of religious orders (both men and women) under the leadership of their bishop. But we know that the omnipotent and wise Lord "who knows the secrets" of man sees all this. The Lord and his love for each individual person is what has motivated, guided, encouraged and supported us. He alone will be for us the final reward.

Jesus Christ did not give many scientific and theological answers to the question of pain and suffering. He preferred simply "to descend to earth and become man" and out of pure love embrace the cross. From that moment until now that cross is the true significance and the answer to the problem of pain and we in Sarajevo and in Bosnia and Herzogovina have striven to share that cross, to carry it together and to die on it with our fellow countrymen and citizens, regardless of differences of religion, nationality, or culture. In this Via Crucis we have sought to wipe away the tears of the suffering, to feed the hungry, to clothe the naked, and to visit and tend the sick. In that great prison which is Sarajevo we were all together. All of this was possible thanks to the support and the paternal help of the Holy Father, very many bishops and priests our brethren, and numerous people who are united and joined with us through the grace of baptism or perhaps simply through a disinterested love for human beings.

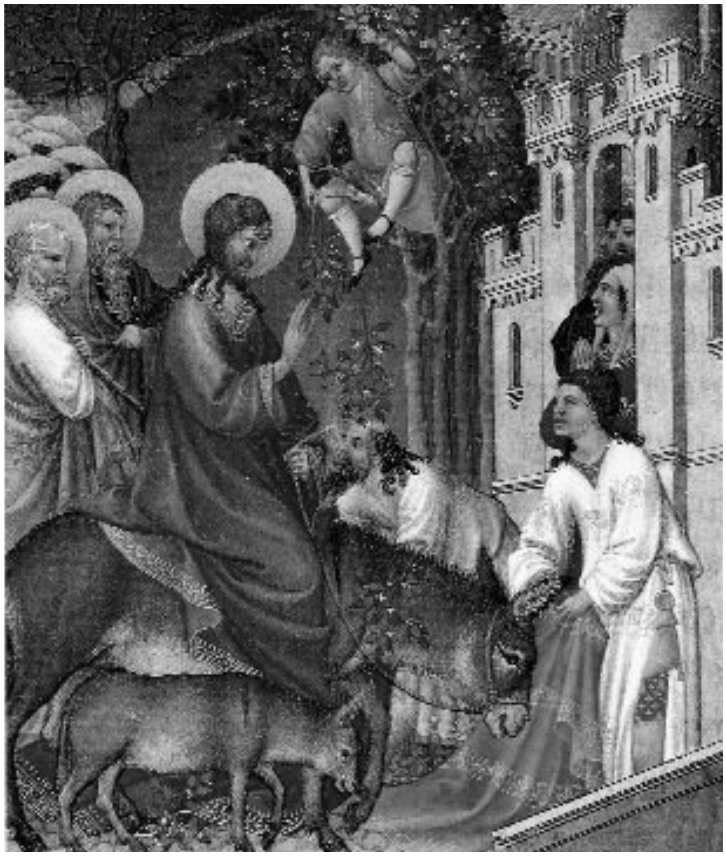
In this epoch more than ever before the Lord Jesus calls upon every one of his disciples to be a compassionate Good Samaritan. We must come to the help of the injured and heal their wounds. But this parable when applied to the international community does not stop here. It is certainly true that the international community must attend to wounds but first and foremost it must stop those who cause these wounds, those who kill large numbers of people to whom by now we are unable to give any form of material help. Before God and the whole world the international community must find the means by which to ensure an effective defense of those who are the weakest of our brethren and those who are oppressed.

If this does not happen the caring for wounds loses almost the whole of its meaning and purpose. But I ask and I ask you: what purpose and logic can there be to attempting to feed the hungry and at the same time knowingly allow them to be killed after they have received food? What purpose and logic can there be to our declarations about the rights of man when these rights are allowed to be so brutally transgressed and betrayed every day?

The Catholic Church is trying and will ever strive to help every man who is in need, but at the same time she will go on condemning violations against man and raising her voice in defense of the rights and the dignity of the human person, of every individual.

Thank you for having given me an opportunity to draw once again the attention of the Church and the medical and political worlds to these very serious questions, concerns and difficulties.

VINKO Cardinal PULJIC
Archbishop of Vrhbosna,
Sarajevo, Bosnia and Herzegovina



BOZO LJUBIC

War Medicine

Taking into consideration that I work in orthopedics, for the past four years I have been in the center of *War Medicine*, and since I have been appointed health minister, I have within reach endless information about suffering and tragedy, especially for specific categories of the population (women, children, wounded, the elderly, etc.). This has influenced me to devote myself exclusively to the analysis of raw facts. However, since this esteemed assembly is devoted to questions of philosphy, ethics, sociology and theology, I could not stay exclusively on an empirical level. Therefore, my knowledge from practical experience is presented as an argument for elaboration, theoretical thinking on a universal plane. In order to introduce the situation to this audience, please allow me to present to you by using statical means, the tragic situation in my country.

At this moment it is very difficult to uncover, and impossible to document all the consequences of this four year war in Bosnia and Herzegovina which unfortunately still continues.

According to information from the Committee for Health and Social Welfare," (Bulletin No. 180. September 25, 1995) since the beginning of the war 146,245 people have been killed, are missing, or have died from cold or hunger. Of this total number 16,838 are children. According to the same source there have been registrations of 174,397 wounded and 12,302 disabled persons.

Estimates are that about 2 million people have moved from their homes (refugees, displaced or exiled persons) within or outside the territory of B&H. This all together prejudicified the definition of the epidemiological picture and the health sector was placed into a position of enormous challenges of a professional medical nature.

In war years there is a registration of a high rate of morbidity from infections and parasitic illnesses, because of difficult living conditions, high migrational movement, lack of healthy water for drinking and hygiene, and a lack of fuel for cooking and heating purposes. Therefore, the average morbidity of infectious illnesses rose from 1358.50 (1990-1991) to 2883.97 (1993-1994). During these war years there has been a registration of significant changes in the structure of movement of infectious illnesses. There was a significant increase in infectious intestinal illnesses which is statistically significant when compared to pre-war years.

The changed epidemological situation requires that medical personnel change their priorities from peace time conditions and place an accent on the care of wounded and the prevention of an epidemic of infectious diseases. Knowledge gathered from military medical acadamies and textbooks of war medicine was not always adequate for our needs. Here there was no organization of stages of care or textbook separations into so called eschalons as it was impossible to strictly implement them anywhere. Civilians and soldiers, children and the elderly, the wounded and the chronically ill, and sometimes the victum and the executioner were treated in the same hospital and sometimes in the same room. Furthermore, not all were fortunate enough to even be treated in appropriate hospitals.

The situation forced us to install several dozen so called war hospitals, which were not military hospitals, but hospitals in which the treatment of already mentioned and not yet mentioned pathologies took place.

The language of cold hard facts have shown the impact of war in a social and health sphere but the question is what do they mean for scientific consideration and in general terms.

Besides this quantified information, as a reflex and consequence of war, there are multiple phenomenons from the areas of health, social pathology, and the work of medical staff.

We are convinced that this enormous experience, tragic and painful, will be used not only by historians but in scientific thought in general.

Our knowledge, it could be supposed, is very relevant for theoretical and philosophical research for war in a modern society, also we will demonstrate this in an outline as elaboration is impossible.

First, every effort to uphold traditional separations of medicine into war and civilian services is impossible and circumstantial. This assumption without doubt can be substantialized by the analysis of practice which is still in progress.

Second, in the type of war which we have come to know in my country, the central problem becomes civilians, the unprotected, and the helpless in their effort to defend themselves from modern weapons. Therefore, no longer is medicine's centers of attention placed on field

hospitals but in urban centres which are devastated from a distance and whose population is killed without selection.

Third, this is not a classical war where there is only the usurpation of territory or the defeat of a nation, but it is an excuse for killing. Thousands of both civilian and military persons have been wounded, imprisoned, or killed just because they belong to another ethnic group.

Fourth, in all earlier wars there was a respect for the rules of the game, and more importantly a respect for international norms and laws. It would appear that this does not hold true any longer, as in fact the *Red Cross*, hospitals, and all medical facilities were central targets of attack.

Fifth, from European history we know that it is very difficult to localize and contain wars in such a small area. Powers have always found reasons to come to the aid of the victim. This was the first time that political Europe for three full years coldly observed a horror evolve from the darkness of the civilized world, and could not summon the strength in the name of morality, universal norms of ethics or at least in anthropological solidarity, to stop the crimes.

It would appear that engaging in the act of lamentation is not productive for ideas or judgments, therefore I will try to put these thoughts in basic terms; presented theortically, whit the entire phenomenon of war and its problems investigate on the level of a theoretical perspective.

Also, if in these considerations we were only to observe the killings, the wounded and the abuse of victims in general, I think that we would only paly reach our goal because that would only address the consequences and I would like to address the causes of the war itself as a phenomenon within the perspective of the current war in my homeland. I would like to speak about the position of doctors in war, upon whose shoulders a great burden has been placed—not as a surgeon or internist, but as a humanist and professional. These doctors have been placed in the position of mitigating the consequences of human destruction upon man himself and also helping man withstand the overwhelming trend of destruction.

Historical knowledge shows us that every civilization has had its own spiritual progressions marked by great and novel accomplishments by which civilizations are separated from one other. In the meantime, along with great accomplishments, civilizations have their own accompaning pathological and dysfunctional occurrences. Sometimes they were a "gift of nature" sometimes from society, sometimes a combination of the two. That

which separates our electronic society from others is its pathological syndromes, which are largely the product of man.

Apparently, the electronic civilization has become entangled in a sea of completely new energies of human destruction; multitudes of occurences represent an entire chain of reasons and consequences. Different forms of degenerations—personal, group, societal, and general: terror, drug addiction, alcoholism, lasciviousness, prostitution, crime, atomic energy aimed against mankind etc—form a synthesis of various side effects of fantastic progress and development.

For his civilization and for his time, St. John described the dangers in the significant eschatological sequences of the *rider of the apocalypse*. Of the four sources of dangers of that time, only WAR remains—that is, if we exclude the phenomenon of death, because death is a consequence, not a cause of the *apocalypse*. Already for four years, in my homeland, 3 of the 4 *riders of the apocalypse* have been riding; plague still hasn't visited us. I observe, however, that only *War* today deserves to be analyzed in detail since the other two are only consequences of war.

War, it could be said, is both a source and consequence, somehow as a natural part of life and death. This thought is not a product of an obsession with the present war in my country; it can be recognized and factually shown. *Hunger* is a standard of the degree of the development of a society, theoretically a non-existent occurrence. Hunger is a determinant of society's unfair model of the distribution and the redistribution of wealth. The *plague,* in its apocalyptic significance, is an unknown disease today. The phenomenon of death belongs to the sphere of the supernatural—that is, unreachable to scientific thought and theory. *War* cannot be stopped by the redistribution of wealth; medical science also has no influence on it; war is not in a supernatural category. War is not within the sphere of religion or science, but is in the final instance a subject of concern for all, that is, a *total phenomenon*. War does not succeed in revealing itself in its true light; it does not have an archtype or a stereotype, except for its etymology; its contents and target always mean death, destruction and antihumanism. War is an unfortunate addendum of progress, and today, and with the use of various methods of destruction, killing and torture, it actually is amenable to the electronic degree of modern civilization. War is a socially determined occurence and does not succumb to natural legal judgements and laws. If war is a part of mankind and a phenomenon whose effects and consequences remind us of a general flood and the extinction of the human species, then the question is What is the place and part of medicine in war?

The shaken morals and ethical values of our civilization, as changes of value scales at a universal level, found their reflection in this war, as did the relationship of the world to this war. Therefore, I

think that it is more appropriate to concentrate on the questions of ethics and morality. *Hippocrates* and the acts of the Biblical *Samaritans* suggest the search for a "new Hippocrates" and Samaritan in our times.

War puts all of those involved to the test. Only in war does the entire ethical value scale receive a new meaning, and doctors fall into trials of whether they will adhere to their responsibilities due to their oaths or whether they will perfidiously break them. In war everything has a new meaning and changes the signs of humanism. Morals, mercy, forgiveness, and sympathy are, in peaceful conditions, the grounds of ethics and morals, encompassing everything. In war this seems and becomes a cynical, contemptible idea. Man evolves into a nothingness; his behavior and deeds are based on killing, revenge, torture, and he is pushed into the need for destruction to the point of complete annihilation. But man, as seen in this war, has also proved to have the highest ethical and moral principles, healing, helping, even sacrificing his own life for another human being.

We, without doubt, discuss ethics, having for an ideal two great historical ethical symbols (the doctor Hippocrates and the paradigmatic biblical Samaritan), and yet we stand before the question of what kind of ethics to nurture and strengthen (and how to do so) in conditions where *bellum omnium contra omnes* functions as a principle in practice.

War, however, does not recognize principles or commands; that is, it very easily re-evaluates them, as we have unfortunately witnessed in our experiences. Here we come to the key question of our analysis, that is, the most important theme. It is not redundant to ask the question: What do those do who treat the body and soul as do murderers, rapists, perverse torturers, men who are filled with destructive energy? How does one come to terms with the fact that we heal such beings, who will, after their spiritual or physical rehabilitation, once again practice killing and crime?! So, a spiritual laborer, who hears confession, gives advice, shows forgiveness and mercy, is almost torn between ethical principles and the reality which is presented to him.

In war, when moral, human and ethical restrictions are abandoned, many become "free" in their choice of behavior. They hate, take revenge, dissolve principles, throw about prejudices and xenophobias; a negative energy is induced in them. Pressured or limited by moral restrictions, their natural impulses can be exposed without fear of feelings of guilt.

In classical wars (even though we have already mentioned that neither

a stereotype nor an archetype exists) enemies were depersonalized except for identification through belonging to a certain nation or group. Meanwhile, the war which goes on in my country, witbout the stains of obsession or emotion, is a completely specific occurrence, I dare to say, even in the history of warfare.

In traditional wars, people are recognized by their uniforms, symbols, signs, and languages, and especially on the grounds of these signs are killed, arrested, imprisioned, and even tortured. Meanwhile, in this war, people subjectively and personally know one another, even doctors. Further, they also know directly or from witnesses their behavior in the war. A criminal is concretely identified and not just by his collective corpus, as in the past. This is the additional pressure on moral people who heal or forgive sins. So, in war, and especially in ours, medicine is no longer only a profession, speciality or vocation of particular merit, but has become a phenomenon important for ethics.

All we have mentioned as forms of social pathology is now in fact a cause and effect relationship. Killing (collective, group, personal, or totally without selection or recognition) and destruction without remainders of anything that has spiritual or material value, are forms of perversity and immorality which have found appropriate space and conditions for themselves in war. The raping of women, girls, grandmothers, in normal conditions, are the methods of psychopaths; here, it would appear, it was a part of the war strategy (reported by an independent international monitor, who accused one side in the war of this). Nothing is too valuable or sacred not be destroyed or humiliated.

So, the moral crisis and insufficient stance in the area of ethics are not empty, rhetorical questions, but are being tested in practice in my country. The specifics of the war in B&H and Croatia deserve attention not only from the medical community but also from philosophical and ethical reflection.

The moral, mental, psychological, emotional, and intellectual structure of doctors is not opposed to thinking that the taking of oaths or the acceptance of universal moral principles can remain unchanged and objectively and professionally function without internal and external conflicts.

It is not difficult to suppose the kind of ethical dilemma a doctor must find himself in when he meets those that are the perpetrators of crime against his own children, wife, parents, collegues or co-workers.

In reality, when this type of war is in question, not even medical personnel are spared from repression and violence in a specific way, because there are no recognizable conventions or international responsibilities regarding human and moral behavior. Let's remember the first days of the siege of Sarajevo. The favorite targets of snipers were ambulances, and one of the first victims in Sarajevo (in which up to this point in time, there have been

over ten thousand killed and over fifty thousand wounded citizens, of whom 1700 are children) was a doctor of the emergency ward, Dr. Silva Rizvanbegovic.

Due to all of this, it would appear that medicine in war is not a pragmatic, empirical question, and not even a problem of traditional morals based on fundamental values.

The problem should be considered and judged alongside phenomenology, philosophy, and ethics. For me, there is no moral dilemma. "The ten comandaments" are an adequate moral orientation; however, this is all a quite subjective understanding of morals, as all medical personnel (as well as the others) are not Catholic, and, in fact, not even religious. Nothing is the same as in the time of the doctor Hippocrates and the biblical times of the merciful Samaritan, whose model of behavior was an exception and not the rule. Jesus used the parable of the Good Samaritan, who was a member of a peripheral group of society, as a lesson for the members of Israel's establishment (pharisees and levites), who passed by the unfortunate person with indifference, and yet they felt that they themselves measured up to the highest moral principles of that time.

We need to speak to the issue of "new ethics" because challenging the process of dehumanization with only noble pacifism and charity, especially in conditions whereby the competition of all values with different meanings has been brought to perfection, cannot guarantee an explicit result. Spiritual leaders, humanists, and other moral sources are doing all that is possible to lessen this frightening moral crisis, but their gains are obviously limited because things are not accomplished now as they were accomplished in the time of great ethical achievements. In the past the entire defense of morality and humanism was aimed at individual or subjective acts. In modern society, individual acts of amorality and immorality are almost marginal in their consequences in comparison to the acts of collective social groups. Apart from this, civilization is threatened by the danger of models of behavior which cannot be explicitly identified as amoral. Let's digress for a moment. We ask if the international community (countries with contemporary democracies or institutions of the UN) of 1991 could have saved hundreds of thousands of lives in the former Yugoslavia, with only credible threats of action such as that taken in 1995.

Ancient civilizations and cultures have always looked for ways to challenge threatened extinction. They were not aware of scientific accomplishments of vast proportions, but they found ways through methods of example to respond to acts of amorality and immorality.

The motto of this conference contains two eminent symbols from the past: the doctor Hippocrates and the Good Samaritan as a paradigm of mercy. The question is whether today we need to find an ideal model of a new Hippocrates or a new Samaritan and not just place them in the medical profession. Another, more substantial question is who and how to heal. That is, medicine always brings to mind the healing of man and his biophysical reality. However, who will heal the collective illness, who will heal social pathology, and where is the location of moral pathology and the source of a possible cataclysm? Their destructive and pathological power is aimed at man, and its spread causes fear and pessimism. There is evidence to substantiate that in only one day in this war in B&H (or Rwanda) there were killings in the thousands of imprisoned or helpless but young and healthy people, and in that same day despite the efforts of thousands of medical workers only a few lives were saved.

Using our empirical knowledge, noticing a correlation between war and medicine, and the significance and role of medicine in an actual cataclysmic war, from the beginning a conclusion has been imposed that only in pure philosophy and phenomenology is it possible to contemplate the problem, on a more generalized level. We consider that only in this way can our experience be of value, if this ever occurs again anywhere.

For understandable reasons, conclusions in the form of hypothetical determinants could not be completely elaborated and argumentatively supported, but we have taken the liberty of separating them:

First, using as an ideal the *New Testament*, scientific thought, especially from the area of ethics, should construct a completely new order of threats against society. The eschatological order of the rider of the Apocalypse, according to St. John, can be useful as a methodological postulate.

Second, through judgements and work on the relationship between war and medicine, we have concluded that ethics has no significant role interest in the important and substanial contents of war. However, I believe that not only medical science but philosophy and ethics can offer much to save the world from ruin.

Third, the moral crisis has taken on a frightening form, and the developmental process of civilization has given it even more substance. However, the question comes up of whether European thought adequately considered the phenomenon of moral crisis and its process. Medicine, even war medicine, is only one small intervening factor which deals with the consequences (in a biophysical, mental and epidemiological sphere) on a personal and not social level.

Fourth, it is surprising that international scientific institutions and organizations from the fields of philosophy, ethics, and morals almost took no interest (it is unknown to us if this was due to a lack of information) in the war in my country.

Everything has been reduced to military presence, monitoring, humanitarian aid and appeals from afar. Here, not far, "2 hours from London," as someone has said, there ensued and is still ensuing, what we hope is an unrepeatable experiment. This is neither an appeal nor a cry from the wilderness, nor is it a warning to scientists (for they are the last to take heed). It appears that from our tragedy we can deduce general judgements and conclusions. This type of tragedy could encompass other countries, even those that think they are out of reach.

Fifth, I don't imagine that a single person or a conference can provide the answers to all the moral dilemmas and conflicts which a war such as this places in front of humanity, and before doctors. Therefore we must turn to the New Testament. If we adequately understand the moral ideals of the Good Samaritan, then we no longer ask the question: "Who is my neighbor?" but "To whom am I closest?", so that the center is no longer "me" but rather "them," "man in trouble," a man who needs our help, be he a friend or enemy, a humanist or a criminal.

BOZO LJUBIC, M.D. Ph.D.,
ORTHOPAEDIC SURGEON
Associate Professor
Minister of Health, R/F B&H