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TO HEALTH CARE WORKERS

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MESSAGE OF THE HOLY FATHER

for THE FIFTH WORLD DAY OF THE SICK

February 11, 1997

1. The next World Day of the Sick will be celebrated on February 11, 1997 at the Sanctuary of Our Lady of Fatima, in the noble nation of Portugal. The place chosen is particularly significant for me. I in fact wished to go there on the anniversary of the assassination attempt I endured in St. Peter's Square, in order to thank Divine Providence, according to whose inscrutable design the dramatic event had mysteriously coincided with the anniversary of the first appearance of the Mother of Jesus on May 13, 1917, at the Cave of Iria.

I am therefore happy that the official celebration of a Day like that of the Sick, which is especially close to my heart, should be held at Fatima. It will afford each of us the opportunity to listen once again to the message of the Virgin, whose basic core is "the call to conversion and penance, as in the Gospel. This call was pronounced at the beginning of the twentieth century and has thus been addressed to this century in particular. The Lady of the message seems to read the signs of the times—the signs of our time—with special insight" (*Allocution at Fatima,* May 13, 1982, in *Insegnamenti* V/2 [1982], p. 1580).

In listening to the Most Blessed Virgin it will be possible to rediscover, in a vital and moving way, her mission in the mystery of Christ and of the Church: a mission which is already found to be indicated in the Gospel, when Mary asks Christ to begin to perform his miracles, saying to the servants at the wedding banquet at Cana in Galilee, "Do whatever he tells you" (*Jn* 2:5). At Fatima She echoed a specific word pronounced by her Son at the outset of his public mission: "The time is fulfilled...; repent and believe in the Gospel" (*Mk* 1:15). The insistent invitation of Mary Most Holy to penance is nothing but the manifestation of her maternal concern for the fate of the human family, in need of conversion and forgiveness.

2. Mary became the spokeswoman for other words of Christ at Fatima. Christ's invitation especially resounded in the Cave of Iria: "Come to me, all you that labor and are overburdened, and I will give you rest" (*Mt* 11:28). Are the throngs of pilgrims who hasten to that blessed land from all over the world not perhaps eloquent testimony of the need for relief and comfort which numberless persons experience in their lives?

Above all, it is the suffering who feel attracted by the perspective of "relief" which the Divine Physician is able to offer those who turn to Him with trust. And in Fatima this relief is found: sometimes it is physical relief, when, in his providence, God

grants healing from illness; more often it is spiritual relief, when the soul, pervaded by the inner light of grace, finds the strength to accept the painful weight of infirmity, transforming it, through communion with Christ, the suffering servant, into an instrument of redemption and salvation for oneself and one's brothers and sisters.

The direction to move in, on this hard road, is pointed out to us by the motherly voice of Mary, who, in the history and life of the Church, has always continued to repeat—and in a special way in our time—the words "Do whatever He tells you."

3. The World Day of the Sick, then, is a precious occasion to hear again and accept the exhortation of the Mother of Jesus, who, at the foot of the Cross, was entrusted with mankind (cf. *Jn* 19:25-27). The World Day is situated in the first year of the Triduum preparatory to the Great Jubilee of the Year 2000: a year entirely dedicated to reflection on Christ. Precisely this reflection on the centrality of Christ "cannot be detached from recognition of the role played by his Most Holy Mother.... Indeed, Mary perennially points to her Divine Son and proposes Herself to all believers as a model of lived faith" (Apostolic Letter *Tertio Millennio Adveniente,* no. 43).

The exemplariness of Mary is conveyed in the most lofty fashion by the invitation to look at the Crucified One so as to learn from Him, who, in completely taking on the human condition, freely wished to burden Himself with our sufferings and offer Himself to the Father as an innocent victim for us men and for our salvation, "with loud cries and tears" (*Heb* 5:7). He thus redeemed suffering, transforming it into a gift of salvific love.

4. Dear Brothers and Sisters who are suffering in spirit and in body! Do not yield to the temptation to regard pain as an experience which is only negative, to the point of doubting God's goodness. In the suffering Christ every sick person finds the meaning of his or her afflictions. Suffering and illness belong to the condition of man, a fragile, limited creature, marked by original sin from birth on. In Christ, who died and rose again, however, humanity discovers a new dimension to its suffering: instead of a failure, it reveals itself to be the occasion for offering witness to faith and love.

Dear people who are sick, be able to find in love "the salvific meaning of your pain and valid answers to all your questions" (Apostolic Letter *Salvifici Doloris,* no. 31). Yours is a mission of most lofty value for both the Church and society. "You that bear the weight of suffering occupy the first places among those whom God loves. As with all those He met along the roads of Palestine, Jesus directs a gaze full of tenderness at you; his love will never be lacking" (*Address to the Sick and Suffering,* Tours, September 21, 1996, 2, in *L'Osservatore Romano,* September 23-24, 1996, p.4). Manage to be generous witnesses to this privileged love through the gift of your suffering, which can do so much for the salvation of the human race.

In a society like the present one, which is seeking to build its future on well-being and consumerism and measures everything in terms of efficiency and profit, illness and suffering, which cannot be denied, are either removed or emptied of their meaning in the illusion of their being overcome exclusively through the means offered by the progress of science and technology.

Illness and suffering no doubt remain a limit and a trial for the human mind. In the light of Christ's Cross, however, they become a privileged moment for growth in faith and a precious instrument to contribute, in union with Jesus the Redeemer, to implementing the divine project of salvation.

5. In the page of the Gospel referring to the Last Judgment, when "the Son of man comes in his glory with all his angels" (*Mt* 25:31), the criteria on the basis of which

the sentence will be pronounced are indicated. As we know, they are summarized in the solemn concluding affirmation: "In truth, I tell you: every time you did these things to a single one of the least of these brothers of mine, you did it to me" (*Mt* 25:40). Among these "least of my brothers" are the sick (cf. *Mt* 25:36), who are often alone and marginalized by society. To make public opinion sensitive to them is one of the main goals of celebrating the World Day of the Sick: to be close to those suffering so that they will be able to make their suffering fruitful, also by way of the help of those who are at their side to provide care and assistance—this is the commitment the World Day is calling for.

Following the example of Jesus, as "Good Samaritans" we must approach suffering man. We must learn to "serve the Son of man in men," as Blessed Luigi Orione said (cf. *Scritti*, 57,104). We must be able to see the sufferings of our brothers and sisters with the eyes of solidarity, not "pass by," but "become a neighbor," pausing at their side, with gestures of service and love aimed at the integral health of the human person. A society is characterized by the attention it devotes to those suffering and by the attitude it adopts towards them.

Too many human beings in the world in which we live remain excluded from the love of the family and social community. In appearing in Fatima to three poor little shepherds to make them announcers of the Gospel message, the Most Blessed Virgin renewed her liberating *Magnificat*, speaking on behalf of "those who do not passively accept the adverse circumstances in personal and social life and are not victims of `alienation'—as it is termed today—but, rather, proclaim with Her that God *raises high the lowly* and, when appropriate, *pulls down princes from their thrones"* (*Homily at the Sanctuary of Zapopan*, January 30, 1979, 4, in *Insegnamenti* II/1 [1979], p. 295).

6. On this occasion, too, I thus renew a *forceful appeal to public leaders, international and national organizations in the health field, health care workers, volunteer associations, and all men of good will, that they join in the commitment of the Church, which, in adhering to Christ's teaching, seeks to announce the Gospel through the witness of service to those who suffer.*

May the Most Blessed Virgin, who has dried so many tears in Fatima, help everyone to transform this World Day of the Sick into a distinctive moment for "new evangelization."

With these wishes, as I invoke the maternal protection of Mary, Mother of the Lord and our Mother, for the initiatives undertaken in connection with this Day, I willingly impart my affectionate Blessing to you, dear people who are ill, your relatives, health care workers, volunteers, and all who, in a spirit of solidarity, are close to you in your sufferings.

From the Vatican, October 18, 1996

Magisterium

Addresses by
the Holy Father

Offer your suffering so as to become main actors on the path leading to the Great Jubilee of the Year 2000

JOHN PAUL II TO PILGRIMS WITH THE FEDERATION FOR TRANSPORTING THE SICK TO LOURDES

In Paul VI Hall, on Saturday, March 23, 1996, the Holy Father received in audience participants in the pilgrimage organized by the Federation for Transporting the Sick to Lourdes. The Pope invited the sick to offer their suffering so as to become main actors on the path of renewal leading to the Jubilee of the Year 2000. A group of Milanese students also took part in the audience.

We publish the text of his address.

1. I welcome you joyfully, dearest Brothers and Sisters of the *Federation for Transporting the Sick to Lourdes*! I also address a warm welcome to you, above all, dear people who are ill, that have faced the discomforts of travel to come to Rome, alongside the tomb of the Apostle Peter.

I greet those in charge of the Association and express my appreciation for this and the other initiatives enabling so many people to live through the intense experience of faith represented by the pilgrimage. I know that the principal motive which has spurred you to come is *to confirm your faith*. I thus want to call to mind, first of all, the words of the Apostle Peter: "Be filled with joy, even if now, for a short time, you must be afflicted by various trials, for the value of your faith, much more precious than gold—which, though destined to perish, is nevertheless tested by fire—will turn to your praise, glory, and honor in the manifestation of Jesus Christ" (*1 P* 1:6-7).

2. The second motive which has led you here is the will *to offer your prayer and your suffering*; it is an offering—it could be termed a spiritual donation accumulated in the concreteness of daily life, especially when life becomes burdensome and requires greater patience.

Dear people, I thank you for the spirit of generous oblation and devout solidarity with the Pope which animate you on this pilgrimage and even more in the ordinary offering of your prayers and sufferings. I thank you and repeat to you what I wrote in the *Message* for the last World Day of the Sick: "To suffer and remain at the side of those suffering: whoever lives out these two situations in faith enters into special contact with the sufferings of Christ and is admitted into sharing 'a most special portion of the infinite treasury of the redemption of the world'" (no. 5).

3. The third motive for your pilgrimage is the intention of actively incorporating yourselves, by turning precisely the condition you are in to good use, into the itinerary *of preparation for the Great Jubilee of the Year 2000*. In this regard, I confirm my exhortation for you to feel yourselves rightfully to be main actors on the road of Gospel renewal which the whole Church is called to travel in these years leading to the Jubilee (cf. *ibid*.). You, dear people, "are called to a special mission in the new evangelization, drawing inspiration from Mary, Mother of love and of human pain. In that far from easy witness, you are supported by health workers, family members, and volunteers accompanying you along the daily road of trial" (*ibid*., no. 2). You are supported, first of all, by Mary Immaculate, whom you love and venerate as the main goal of your earthly pilgrimages and of the great pilgrimage of life. May my Apostolic Blessing also accompany you, which I now impart with great affection for you that are present here and willingly extend to those who have not been able to come, along with the members of your families.

The following words of greeting were addressed by the Pope to a group of students from Milan.

I am happy to welcome the secondary school students of the Collegio San Carlo of Milan, who have come on the occasion of the 125th anniversary of the foundation of their school, which is proud to have among its former students Achille Ratti di Desio, later called by Providence to become Pope, bearing the name of Pius XI.

Dear young people, you are about to complete a phase of your schooling and begin a new stage in your human and Christian growth. I hope you and all your friends at San Carlo will live out your age as an openness to life, always recalling what Jesus once said to his disciples: "I am Life." Yes, dear young people, follow Jesus and your lives will be full of goodness and joy! I bless you from my heart, together with those educating you.

Continue to work in accordance with your Founder's example

TO MEMBERS OF THE RAOUL FOLLEREAU GROUP, APRIL 27, 1996

Mr. President, Ladies and Gentlemen, Dear Friends:

1. It is a source of great joy for me to receive you here and, through you, to receive the whole *Raoul Follereau Group*, which I am pleased to greet in its numerous branches, along with the members comprising it, the families represented by it, the donors supporting it, and the hundreds of thousands of patients who have already been cured or are on the way to being cured, who are its first reason for existence. I wish to convey to you my deep thanks, Mr. President, for your impassioned presentation of the person and work of your founder, in addition to the humanitarian group guided by you.

First of all, I wish to give thanks to God for the results obtained in half a century, since the day Raoul Follereau decided to consecrate himself to fighting against the scourge of the disease afflicting whole nations, preventing thousands of human beings from leading a life worthy of this name. Stirred by the hardships of these poor people, whose bodies had become a painful prison for them, he placed himself at their service with contagious enthusiasm. As a true Christian he took serious Christ's statement: "Whenever you did these things to just one of the least of these brothers of mine, you did it to me" (*Mt* 25:40).

Endowed with a multifaceted personality, Raoul Follereau was able to associate complementary qualities within himself which, when joined together, permitted extraordinary achievements. He had the virtue of compassion: "I have always been obsessed," he wrote, "with misery and ever filled with admiration for those combating it at any level." Though aware of the "impossibility of embracing all the misery in the world," he nevertheless made a complete gift of himself to overcome misery: "I thought that there was more than enough in this field to fill the life of a young person, as I then was. And so I consecrated myself."

2. Fortified by this example, you have a heartfelt desire to continue his activity and a still immense field before you, for, not content to combat leprosy, you combat every kind of leprosy with the same energy! Your activity, starting from Adzopé, the first village of lepers, founded in 1942, has radiated out into every continent. In distant countries, as well as in your cities and their outskirts, hidden forms of misery are not lacking, desperate situations involving broken lives to which you seek to bear the comfort of the word and action, of smiles and friendship, of compassion and the gift of yourselves.

I congratulate you and exhort you to continue to work in the countries shaken by war or scourged by epidemics. "Our appeal," Raoul Follereau would say, "will always be up-to-date." He also echoed the words of Christ: "Indeed, you always have the poor with you" (*Jn* 12:8). And you will be able to involve the most unfortunate in the patient work enabling them to rediscover their dignity, for you never deal with cases, but with persons.

3. As you have already been doing for some time, you cooperate with the Church on all continents to unite your forces and bring about the victory of life. I wish to convey forcefully my esteem, trust, and gratitude for what you are doing. Raoul Follereau has traced out the path for you, having himself followed Christ, who is life (cf. *Jn* 14:6). By learning from him you will be able to determine what is just and good and carry it out enthusiastically.

May God accompany you, my dear friends! May he carry out by means of you what He Himself has begun! To encourage you in your work, a source of hope, I wholeheartedly impart my Apostolic Blessing and extend it to your loved ones.

“Dear people who are ill, join your sufferings to the Cross of Christ and pray for the ministry which is entrusted to me”

THE HOLY ROSARY IN THE CATHEDRAL
ON THE FIRST SATURDAY OF THE MONTH (COMO, ITALY)

In the Cathedral of Como, John Paul II led the Holy Rosary on the evening of May 4, 1996, the first Saturday of the month. At the conclusion, addressing the numerous priests, men and women religious, and lay people—including a group of the sick—who joined with him in the Rosary, the Pope addressed to them the following words of greeting.

Dearest Brothers and Sisters!

1. I am happy to have been able to say the Holy Rosary together with you in this Cathedral devoted to the Assumption of the Blessed Virgin Mary. The last time I said the Rosary this way, in October 1995, was at St. Patrick’s Cathedral in New York. A good sign! This year is the sixth-hundredth anniversary of the beginning of construction here. The harmonious building, with its splendid structures and suggestive frescoes, creates a sacred atmosphere in which it is easy to become recollected and pray.

We are invited by the numerous representations of Mary in the church to approach the Mother of God and our Mother trustingly. On Calvary Jesus entrusted us to Her so that She would lead us by the hand in every moment of life, towards ever-deeper adherence to God’s providential designs regarding each of us.

I express my affection to you, first of all, dear people who are ill, whom I am pleased to see here in front, as well as all the infirm who have been able to take part in this moment of prayer. In faith, be able to unite your sufferings constantly to the victorious cross of Christ and also pray for me and for the ministry which is entrusted to me.

I thank you, dear priests present here, and those who, by way of radio and television, have joined us spiritually to say the Rosary. I exhort everyone, especially in this month of May, which popular devotion dedicates to Our Lady, to say the Holy Rosary confidently. Dear priests, also invite the families and communities entrusted to you to recite the Rosary frequently, a most effective prayer for requesting heavenly gifts.

I cordially greet and thank the many women religious, and hope they will increase in vocations. You don’t know how necessary you are! I also greet the many faithful who in different ways have taken part in this encounter, both inside and outside the Cathedral. I convey my affectionate regards to each of you.

The Salvific Significance of Suffering

WORDS TO SOME "VOLUNTEERS IN SUFFERING" FROM HONG KONG, MAY 31, 1996

It is with great joy that I welcome the group of *Volunteers in Suffering* from Hong Kong and the *Silent Workers of the Cross* assisting you during your visit to Rome. Your faith and your courage in the face of suffering make this encounter a special, significant moment for the Successor of Peter. I encourage you in your self-offering and in your apostolate.

You already know that your sufferings can introduce you into the essence of the Christian mystery. In his letter to the Colossians, the Apostle Paul writes, "I am happy in the sufferings I endure for your sake and complete in my flesh what is lacking to the sufferings of Christ for the good of his body, which is the Church" (1:24). What St. Paul is saying is that the Crucified and Risen Christ is especially joined to those who over sin. He is our Savior, and no one can increase his work of Redemption. But through the mystery of the Church, his body, He introduces us into his sacrifice, in such a way that we discover—in the daily struggle with our limits—*the salvific significance of suffering.* At that point inner peace and even spiritual joy are possible (cf. *Salvifici Doloris,* no. 26).

For the Christian infirmity, illness, and other afflictions are not something to resign oneself to passively. *Suffering belongs to the transcendent nature of man:* it is one of the spheres in which men and women, and even children, are rendered capable of virtuality going beyond themselves. When accepted and endured in faith, suffering becomes the instrument for our sanctification and that of others. It becomes a source of redemption for the whole of humanity.

I am sure that the Hong Kong Center of the *Volunteers in Suffering* has an important role to play in the spiritual life of the local Church, communicating that mysterious vitality which comes from devoted union with the Crucified Lord and bearing witness *to the power of the Gospel to transform even the most difficult situations.* I encourage the *Silent Workers of the Cross,* including the group of novices present here today, to persevere in living out and sharing with others te charism which your founder, Monsignor Novarese, has left you.

May Mary, Consoler of the afflicted, be close to all of you.

And as a sign of strength and peace in the Lord, I wholeheartedly impart to you my Apostolic Blessing.

New forms of real solidarity to respond to the multiplication of attempts on human dignity

ENCOUNTER WITH THE SICK AND THE SUFFERING AT ST. MARTIN'S BASILICA IN TOURS, FRANCE

On the afternoon of Saturday, September 21, 1996, John Paul II visited St. Martin's Basilica in Tours, France, where he presided at a Celebration of the Word. During the visit, the Holy Father met with the sick, the disabled, the poor, and the elderly.

We publish a translation of the Pope's homily.

Dear Brothers and Sisters:

1. "Blessed are you, for yours is the Kingdom of Heaven"! I greet all of you with affection, for I attach great importance to this encounter of ours. Your faces express hope; your faces also speak of God, for you possess value in his sight. *St. Martin* is bringing us together this afternoon at the Basilica containing his tomb. Throughout his life he sought to live out the message of the Beatitudes fully, precisely the message we have just heard again. He accompanies us invisibly; I ask him to come to enlighten us, since he was one of the great Apostles of the Gospel in your land. *In him, the Church recognizes the example of the Christian totally devoted to his neighbor*: he gave his life for his brothers and sisters, following Christ.

Each of the Beatitudes was lived out by St. Martin: poor in heart, he awaited all things from God, without relying on his own physical, intellectual, or spiritual strength. In a spirit of abandonment, he knew that the will of Christ for him was his only reason for existence. *Gentle* by nature, he abandoned arms to serve his neighbor. *Moved* by the spiritual misery of his time, he went about the countryside, "announcing the Good News to the poor, liberation to prisoners, and joy to the afflicted." *Hungry and thirsty for justice*, he was able to establish a lifestyle in keeping with the justice of God surpassing that of men. "United to the Lord by most tender mercy" (Sulpicio Severo), he was *a man of forgiveness* and came to the aid of the poor whom God placed along his way. A man *with a pure heart*, he knew how to resist temptations. *A peacemaker*, he succeeded in solving many conflicts in his time, without refusing "the burden of the day's work and the carding thistle" (*Mt* 20:12). *Persecuted for the sake of justice*, he showed that Christ fills all life and deserves to be followed, at whatever price.

2. In current society we are familiar with *too many forms of poverty*, sadness, and affliction. Material poverty, illness, physical suffering, and the different types of exclusion which afflict out contemporaries. The forms of unhappiness are multiple: no one can be sure about eluding them in the course of life. Some undergo more than one form, for they generate each other. A time comes when every way out seems to be closed, when life no longer appears to be a gift of God, but rather a burden. It is then that the beatitude of the afflicted takes on its full meaning. Christ dared to proclaim that those who weep are blessed and will be consoled (cf. *Mt* 5:5). He affirmed that they are called to eternal happiness. Thanks to his infinite love, the Lord thus responds to the desire for happiness dwelling in the heart of each man. Indeed, what is greater or more important than *being loved and recognized for oneself, for the beauty of one's inner being*, which does not depend on appearances or on the

immediate interest which one may hold for others?

Like St. Martin, we are invited to open our eyes and recognize in the poor man dying of cold at the city gates, in the stranger knocking at our door, a brother to be welcomed and loved. *A society is judged by the gaze it directs at those suffering in life* and by the attitude it adopts towards them. Each of its members must answer one day for his or her words and acts in regard to those at whom no one looks, from whom people turn away. Regarding the poor man of Amiens, it is stated in the *Life of St. Martin*, "no matter how he pleaded that passers-by have mercy on his wretchedness, all continued on their way without stopping" (3,1). Because of their difference, they were unable to recognize their brother. Ignoring their neighbor, they mocked a part of their own humanity. That day none of them were able to see Christ dying of cold in the person of the poor man.

Every *being tormented* in body or spirit, all persons deprived of their basic rights are *a living image of Christ*. "In the poor and the suffering, the Church recognizes the image of her Founder, poor and suffering" (Constitution *Lumen Gentium*, no. 8). By his death on the cross, Christ, who experienced extreme suffering, remains close to us. By contemplating the mystery of his Passion, we nevertheless discover the hope offered by the Lord. Through his love for us, He has opened up a new road for us. By his Resurrection on Easter morning, He testifies that *death and suffering no longer have the last word regarding man* and that a future is always possible. An existence which, on a human level, might seem closed into a blind alley has become a passage. Yes, dear friends, you that bear the weight of suffering occupy the first places among those God loves. Like all whom He encountered along the roads of Palestine, Jesus has directed towards you a gaze filled with tenderness; his love will never be lacking. For you have been children of God since your origin; you occupy a special place in the Church, the Body of Christ.

In the face of the multiplication of attempts on the dignity and integrity of persons, *in the face of an increase in the number of those excluded, new lifestyles must be found*, both personal and collective, which enable crises to be overcome, particularly in those countries which, like yours, have abundant human and natural resources available. *New forms of solidarity* must be brought into being, both inside each society and among nations. To guarantee everyone access to work, wouldn't it be appropriate to re-examine some practices and foster a more equitable distribution of goods? Are those with the good fortune to have sufficient incomes willing to share them more with those who don't manage to live in an acceptable manner? A more frugal lifestyle would enable many to avoid waste and be more attentive to the needs of their neighbor.

All human beings, no matter how needy, have been created in the image and likeness of God, and nothing can cause them to lose this dignity. Whatever their origin may be, whatever the burden of their trial may be, to refuse to see them means to condemn oneself to not understanding anything about life.

3. Let us listen to the message of the Beatitudes: "Blessed are the merciful, for they shall obtain mercy"! (*Mt* 5:7). The mercy Christ is speaking of is the tenderness of God; forgiveness is a major expression of it. The merciful heart thus lets itself be moved by the misery of others and remains restless until it has done everything in its power to bring comfort to those experiencing need. To enter into the Kingdom, it is necessary to have *this merciful heart*, not only sensitive to need, but also *capable of alleviating suffering, shattering solitude, and actively committing oneself to welcoming one's brothers and sisters who are less fortunate*.

The merciful shall obtain mercy. "Every time you did these things to just one of these least of my brothers, you did it to me" (*Mt* 25,40), Christ will say to them on the last day. The happiness of eternity will be the happiness of seeing God and recognizing Him in the person of all who have been placed along our way by Him, with whom we shall live forever by the love which never ends. This happiness is perceived by us, beginning now. The Gospel invites us to *act in brotherly fashion towards our neighbor*, precisely *because God is present in him* and awaits us. The relationship with God is inseparable from love for our neighbor, particularly in the poor we encounter.

4. Attention to the poor constitutes one of the basic criteria for belonging to Christ. It must characterize the temporal commitment of the Christian. Faith must be accompanied by action favoring our brother and sisters sharing our humanity, for "the love of Christ spurs us" (*2 Co* 5:14) to serve all men, those we love and those we do not love enough. This is why *I make an appeal for real soli-*

darity among all. When will each person's right to work, then, be truly respected—to housing, to culture, to health, to an existence worthy of this name? The Church would seriously fail in her mission if she did not recall this impelling duty to do everything possible, in the rich societies of the West and in every society, to overcome the scourges which do not cease to lash the surface of our planet. Christ came to "announce a glad message to the poor" (*Lk* 4:18). None of his disciples and none of his brothers and sisters are dispensed from taking part in this demanding, salutary, and gratifying work.

5. May St. Martin guide you every day! May he inspire you with words, gestures, and attitudes of love, brotherhood, and compassion which will help you to live! For 1600 years he has been interceding before the Father on behalf of those who have turned to him trustingly. If you pray to him, he will not abandon any of you, none of those he sees suffering along the tortuous ways of life. At the gates of Amiens, Martin donated half his cloak. May he continue to be our model of real, authentic charity!

As a sign of the love coming from God, as a pledge of the hope based on Christ, I wholeheartedly impart to you the Apostolic Blessing and extend it to all whom you represent, to those suffering on account of a wound and asking the Lord to come and heal it. I want to say it to our world: sharing is a source of happiness! Joy is possible! May God keep you always!

The value of human suffering is great in the redemptive work of Christ and the Church

WORDS FOR THE SICK AND THE ELDERLY AT THE HOUSE OF ST. ADALBERT IN HUNGARY

On the afternoon of Friday, September 16, 1996, the Holy Father visited the elderly and the sick living at the House of St. Adalbert hospice at Pannonhalma Abbey, Hungary. It was a particularly intense and moving visit.

We publish a translation of the Pope's words.

During my pilgrimage to Hungary, I regard as important this visit—though brief—to you, dearest Brothers and Sisters marked by illness and the burden of years. I thank you for having invited me, thus bearing witness to the affection and spiritual closeness of each of you in relation to the Pope. My thoughts go out to those who, on account of infirmity and age, are sharing in this visit of mine from their homes, their clinics, and their hospitals. My heartfelt thanks to you all, especially for your prayers! The value of human suffering is great, and the contribution of the so-called "senior citizens" is indispensable!

The condition of *illness* is an ambivalent state: on the one hand, in impeding persons in various ways, it leads them to experience their limits and their fragility; on the other, in placing them more directly in contact with the Cross of Christ, it enriches them with new possibilities. By offering their sufferings to Christ, the sick can make a personal contribution to his work of redemption and actively share in the edification of the Church.

The *elderly* also constitute an extremely valuable presence for the family and society. You elderly people are the guardians of a very rich patrimony of values and experiences. Do not keep it locked within yourselves, but communicate it to those who are younger, with wisdom and discretion, and they themselves will be grateful to you for it.

Dearest Brothers and Sisters, may the Virgin Mary enable you to live through your condition in the fullness of faith and to find attention, a willingness to listen, and solidarity in others. From the heart I impart to each of you and to all the sick and elderly in this beloved country a special Apostolic Blessing, which I willingly extend to the people who generously labor to provide care.

Topics

Faith and the Treatment of Suffering Patients

Technology and Human Dignity

The Chaplain, Religious Assistance, and the Chaplaincy

Faith as a Transcendent Element Facilitating Therapeutic Results in Suffering Patients

A BLIND STUDY OF SUBJECTS EXPERIENCING CHRONIC PAINFUL PATHOLOGIES

The purpose of the present study is a) to consider the ways in which the transcendent element of faith can have an influence on the pain perception threshold and on responses to therapy and b) to provide a theological interpretation of this phenomenon as well.

A) Clinical and Statistical Formulation

Material and Method

The blind study (that is, involving no prior knowledge of patients' religious convictions) was carried out on 120 people admitted to General Medicine wards for chronic painful pathologies. On their arrival in the ward the pathology responsible for their condition was verified; they were then subdivided on a random basis (chance assignment) into two groups. A group of sixty patients (the study group) received a pharmacological therapy involving nonsteroid antiphlogistic drugs and vitamin C, administered parenterally (3 g of ascorbic acid and 1 g of acetylsalicylate of lysin in 250 cc of physiological serum); in addition, these subjects also underwent a test (which we designated the "Spiritual Transcendence Test" or "STT"), consisting of reading and meditating on a passage capable of stimulating their interior patrimony. The passage, taken from St. John's Gospel, was handed to patients, who were invited to read it carefully.[1]

A second group of sixty patients studied at the same time (the control group) followed a pharmacological treatment identical to that of the study group, but they did not undergo the STT.

Treatment was to last ten days. During this period the patients participated in a daily subjective evaluation of pain, before and two hours after the administration of drugs, and, in the study group, after the simultaneous administration of the STT.

Pain intensity was evaluated by way of an Visual Analogical Scale (Fig. 1)—"VAS"—in which there are no fixed reference points, except for the basic level indicating "no pain" and the maximum level indicating "the most intense pain imaginable" (J. Scott, E.C. Huskisson, 1976). The VAS is a vertical line ten centimeters long with the aforementioned levels, on which patients are to indicate the intensity of their pain (cf. Fig. 1). The reading of the VAS was done through a scale divided into 100 mm, and observations were thus expressed in an ordinal numerical scale.[2]

At the end of treatment—that is, after the tenth day of hospitalization—patients were asked whether or not they were believers, and two subgroups were thereby obtained from the two initial groups.

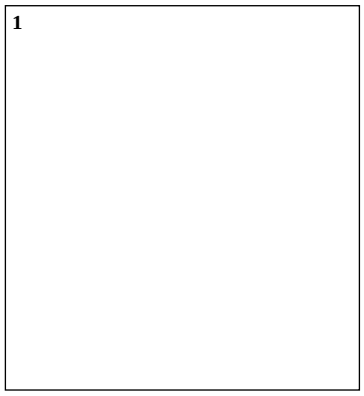


Fig. 1 – Representation of the method for measuring pain according to the Analogical Visual Scale (VAS); The patient is asked to indicate the level of personal pain along a verticle line ten centimeters in length; the numerical value of the patient's written indication is then established.

In practice, four groups were delineated in the end on the following basis.

Group c1. Believing patients treated with the STT (37 subjects) (Tab. I).

Group a2. Agnostic (nonbelieving) patients treated with the STT (23 subjects) (Tab. II).

Group c3. Believing patients to whom the STT was not administered (34 subjects) (Tab. III).

Group a4. Agnostic (nonbelieving) patients to whom the STT was not administered (26 subjects) (Tab. IV).

The statistical processing of the findings was done on the first (T0a e b), fifth (T5a e b), and tenth (T10a e b) day of therapy by way of statistical analysis (a=the beginning of treatment, b=verification after two hours).

The first statistical verification aimed to ensure that the distribution of pathologies was the same in the groups of believers (c groups) and agnostics (a groups). By simply indicating basic VAS with **"V1"** and the difference between V1 and the final VAS score with **"Vd"** research was done to determine whether the distribution of values in V1 (basic pain threshold) and Vd (raising of the threshold after therapy) was the same among the following groups.

a) *Believers and agnostics* (regardless of the administration of the STT): subjects (c1+c3) and (a2+a4).

b) *Subjects administered the STT and those not administered it* (regardless of ethical-religious orientations): subjects (c1+a2) and (c3+a4).

c) *Believers administered the STT and those not administered it:* subjects c1 and c3.

d) *Agnostics administered the STT and those not:* sub-

TABLE I – **Group c1:** Believers treated with S.T.T.

Patient	Sex	Pathology	VAS T0a	VAS T0b	VAS T5a	VAS T5b	VAS T10a	VAS T10b
1	m	Lombosciat.*	6	5	5	4	4	3
2	m	Emicrania	5	5	4	3	3	3
3	m	ETP pancr.	6	6	5	6	6	4
4	m	ETP colon	7	6	7	7	7	5
5	m	Dol. deaff.	6	6	5	4	4	3
6	m	Gonartrosi	6	4	5	4	4	3
7	m	Per. sca. om.	6	5	5	4	4	3
8	m	Artr. cerv.	4	3	3	3	3	2
9	m	Sacroileite	5	4	4	2	2	2
10	m	Artr. lomb.	6	5	5	3	3	3
11	m	Cef. grapp.	6	6	6	6	6	5
12	m	Lombosciat.	7	6	6	5	5	5
13	m	Artr. cerv.	4	4	4	3	3	2
14	f	Cef. musc.	3	2	2	2	2	2
15	f	Gonartrosi	6	5	6	3	3	3
16	f	Lombosciat.	4	4	4	3	3	3
17	f	Emicrania	6	5	5	1	1	2
18	f	Artr. cerv.	3	2	2	2	2	1
19	f	ETP mamm.	7	7	6	8	8	6
20	f	Cef. musc.	3	2	2	1	1	1
21	f	Coxartrosi	5	3	2	1	1	1
22	f	Artr. lomb.	4	4	4	3	3	2
23	f	Lombosciat.	5	5	5	4	4	3
24	f	Lombosciat.	4	3	1	3	3	1
25	f	Nevr. trig.	6	7	6	6	6	5
26	f	Cef. musc.	5	4	4	3	3	3
27	f	Emicrania	5	4	4	4	4	3
28	f	ETP mamm.	8	7	7	7	7	6
29	f	Art. reum.	5	4	5	4	4	3
30	m	Cef. musc.	5	4	5	4	4	3
31	m	Art. reum.	5	4	4	4	4	4
32	f	Artr. cerv.	5	4	4	4	4	3
33	f	Emicrania	5	4	4	4	4	3
34	f	Cef. musc.	5	5	4	4	4	2
35	f	Emicrania	5	4	4	4	4	3
36	f	Emicrania	5	4	5	4	4	3
37	f	Nevr. trig.	5	4	5	3	3	3
Average V.A.S.			5,216	4,486	4,432	3,891	3,783	3,432
D.S.			1,11	1,28	1,36	1,42	1,59	1,27

TABLE II – **Group a2:** Nonbelievers treated with S.T.T.

Patient	Sex	Pathology	VAS T0a	VAS T0b	VAS T5a	VAS T5b	VAS T10a	VAS T10b
1	m	Artr. poliart.	6	5	4	6	6	6
2	m	Lombosciat.	7	6	5	4	4	5
3	m	ETP gastr.	8	6	5	5	5	6
4	m	Artr. cervic.	5	4	5	4	4	4
5	m	Artr. lombar.	6	5	6	5	5	5
6	m	ETP gastr.	7	6	6	5	5	5
7	m	Nevr. trigem.	7	6	6	5	5	5
8	m	Gonartrosi	6	4	4	5	5	4
9	m	Lombosciat.	6	5	6	5	5	5
10	m	Coxartrosi	6	6	5	5	5	4
11	f	Lombosciat.	7	6	6	4	4	4
12	f	Emicrania	6	5	4	4	4	4
13	f	ETP mamm.	8	7	6	6	6	6
14	f	Lombosciat.	6	5	5	5	5	5
15	f	Artr. reumat.	7	6	6	6	6	6
16	f	Artr. lombar.	6	6	5	5	5	4
17	f	ETP mamm.	7	6	5	5	5	5
18	f	Coxartrosi	6	5	4	5	5	4
19	f	Sacroileite	5	5	6	4	4	4
20	f	Lombosciat.	5	5	5	4	4	4
21	f	Nevr. trigem.	6	5	5	5	5	4
22	f	ETP utero	6	5	5	5	5	5
23	f	Coxatrosi	6	5	4	5	5	4
Average V.A.S.			6,31	5,4	5,14	4,7	4,87	4,7
D.S.			0,81	0,71	0,75	0,55	0,62	0,75

* N.B. The abbreviations for pathologies in these tables have been left in the Italian original.

TABLE III – Group c3: Believers not administered S.T.T.

Patient	Sex	Pathology	VAS T0a	VAS T0b	VAS T5a	VAS T5b	VAS T10a	VAS. T10b
1	m	Lombosciat.	6	5	5	5	5	5
2	m	Coxartrosi	5	5	4	4	4	4
3	m	Lombosciat.	7	6	7	5	5	5
4	m	Artr. cerv.	4	4	3	3	3	3
5	m	Emicrania	5	4	4	4	4	4
6	m	Cef. grapp.	7	6	6	5	5	4
7	m	Gonartrosi	6	5	5	6	6	4
8	m	Artr. lomb.	4	5	4	3	3	4
9	m	ETP polmoni	6	4	5	3	3	4
10	m	Artr. cerv.	4	2	2	2	2	3
11	m	Nevr. trig.	6	6	6	5	5	5
12	m	ETP gastr.	8	7	7	7	7	6
13	f	Cef. musc.	4	3	2	2	2	2
14	f	Artr. cerv.	2	2	1	0	0	1
15	f	Nevr. herp.	7	5	4	4	4	4
16	f	Artr. lomb.	6	5	6	5	5	4
17	f	Emicrania	4	3	4	3	3	2
18	f	Emicrania	5	3	3	3	3	3
19	f	Lombosciat.	5	7	5	4	4	2
20	f	Coxartrosi	4	3	2	1	1	2
21	f	ETP utero	7	6	6	6	6	5
22	f	ETP mamm.	7	6	7	6	6	5
23	f	Cef. musc.	3	3	3	3	3	2
24	f	Cef. musc.	3	2	2	2	2	1
25	f	Lombosciat.	7	7	6	4	4	3
26	f	ETP. gastr.	6	6	7	4	4	4
27	f	Emicrania	6	5	5	4	4	2
28	f	Lombosciat.	6	7	6	5	5	3
29	f	Gonartrosi	4	4	4	3	3	3
30	m	Cef. musc.	5	4	6	5	5	4
31	f	Coxartrosi	5	5	4	5	5	5
32	f	Artr. reum.	5	5	5	4	4	4
33	f	Cef. musc.	5	5	5	4	4	4
34	f	Coxartrosi	3	3	4	4	4	4
Average V.A.S.			5,21	4,64	4,55	4,17	3,91	3,52
			1,41	1,47	1,61	1,61	1,46	1,21

TABLE IV – Group A4: Nonbelievers not administered S.T.T.

Patient	Sex	Pathology	VAS T0a	VAS T0b	VAS T5a	VAS T5b	VAS T10a	VAS T10b
1	m	Artr. reum.	6	5	5	4	4	5
2	m	ETP prostata	8	6	6	6	6	6
3	m	Lombosciat.	6	6	5	5	5	5
4	m	Nevr. herp.	7	7	6	4	4	5
5	m	Gonartrosi	6	5	6	5	5	6
6	m	Cef. grapp.	7	6	6	5	5	6
7	m	Lombosciat.	6	6	7	4	4	5
8	m	Per. scap. or.	6	4	5	4	4	4
9	m	Artr. cervic.	6	5	5	4	4	4
10	m	Artr. reum.	6	6	7	6	6	5
11	m	Coxartrosi	7	5	6	4	4	4
12	f	Artr. reum.	7	6	6	6	6	6
13	f	Nevr. trig.	7	6	7	6	6	6
14	f	Cef. musc.	7	6	7	6	6	5
15	f	Artr. lomb.	6	6	5	5	5	4
16	f	Artr. lomb.	6	5	5	5	5	5
17	f	Gonartrosi	5	4	4	4	4	4
18	f	Nevr. trigem.	6	5	6	5	5	6
19	f	ETP mamm.	8	6	7	5	5	7
20	f	ETP pancr.	7	6	6	6	6	5
21	f	Lombosciat.	6	6	5	5	5	5
22	f	Emicrania	7	6	6	6	6	6
23	f	ETP mamm.	7	6	5	6	6	6
24	f	Emicrania	6	5	6	6	6	5
25	f	Lombosciat.	7	7	6	6	6	6
26	f	Lombosciat.	7	6	7	6	6	6
Average V.A.S.			6,53	5,65	5,81	5,11	5,15	5,26
D.S.			0,69	0,73	0,87	0,64	0,81	0,81

jects a2 and a4.

e) *Subjects administered the STT, both believers and nonbelievers:* subjects c1 and a2.

f) *Subjects not administered the STT, both believers and nonbelievers:* subjects c3 and a4.

This research aimed to determine whether

a) believers have a basic pain threshold which is higher than that of agnostics;

b) therapy obtains better results with believers than with nonbelievers;

c) the STT raises the basic pain threshold;

d) the STT improves the results of therapy.

We have observed, however, that in the analysis of asymmetrical distributions, like those of the Vd variable, the Student T test is not the most suitable for identifying differences among distributions.

More appropriate is the Wilcoxon Test[3] or the Mann-Whitney Test[4]—that is, the tests belonging to the so-called "central tendency" group. These are suited to identifying differences between two distributions. In this instance, we used the **Mann-Whitney U Test.**

Findings

Pathologies proved to be equally distributed to a satisfactory degree in the different groups.

In Tables I-IV the values, **means,** and **standard deviations (SD)** are reported for groups in the six consecutive VAS measures.

In figure 2 the mean value for the four groups in six consecutive VAS measures is represented.

In figure 3 the different distributions of the four groups (c1, a2, c3, a4) for V1 (on the left) and for Vd (on the right) are represented.

In figures 4 and 5 the distribution pairs for V1 and Vd are shown—on the left, those administered (c1+a2) and not administered (c3+a4) the STT; on the right, believers (c1+c3) and nonbelievers (a2+a4).

In figures 6 and 7, the distribution pairs are shown for V1 and Vd, respectively, in subjects to whom the STT has or has not been administered—on the left, believers (c1, c3); on the right, agnostics (a2, a4).

In figures 8 and 9 the distribution pairs are shown, respectively, for V1 and Vd in believers and agnostics—on the left, those to whom the STT has been administered (c1, a2), and, on the right, those to whom it has not been administered (c3, a4).

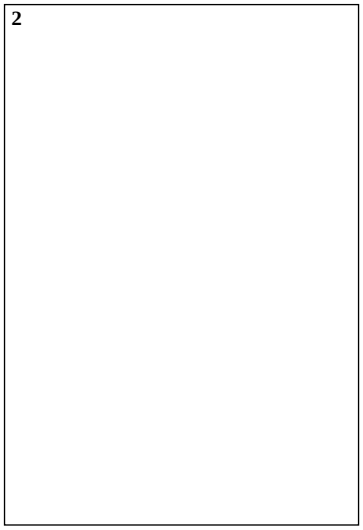
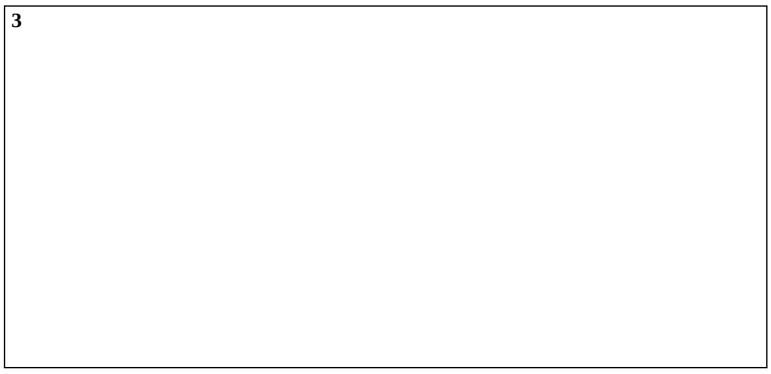


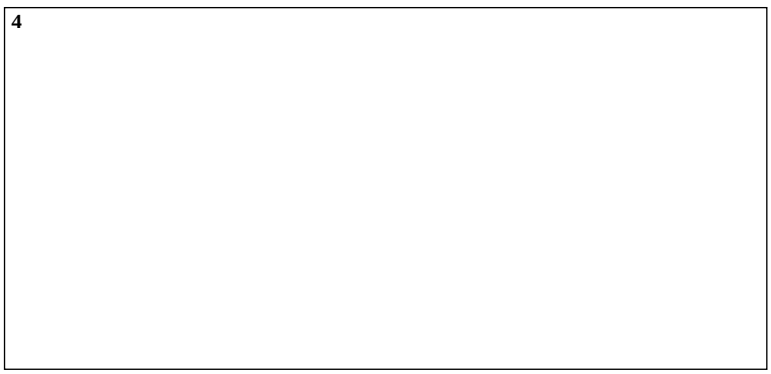
Fig. 2 – The average VAS for T0a, T0b, T5a, T5b, T10a, T10b, in groups c1, a2, c3, a4.

Fig. 3 – Distributions of V1 (on the left) and Vd (on the right) in groups c1, a2, c3, a4.

Fig. 4 – Distribution of V1 in the groups listed together: on the left, subjects with and without STT (c1+a2, c3+a4); on the right, believing and agnostic subjects (c1+c3, a2+A4).

Fig. 5 – Distribution of Vd in the groups listed together: on the left, subjects with and without STT (c1+a2, c3+a4); on the right, believers and agnostics (c1+c3, a2+a4).





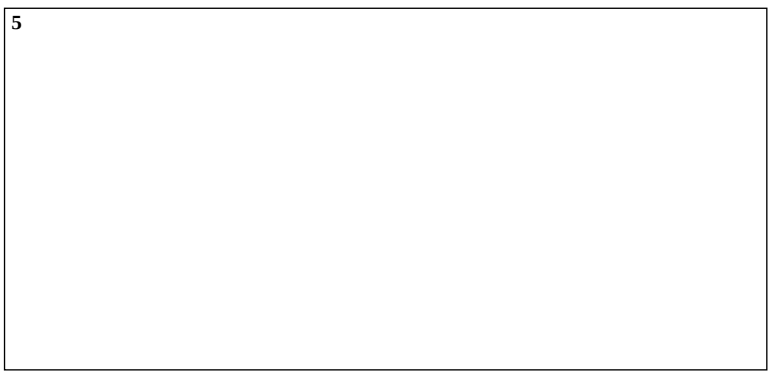


Fig. 6 – Distribution of V1 by groups (the effect of administering STT: on the left, believers with and without STT (c1, c3); on the right, agnostics with and without STT (a2, a4).

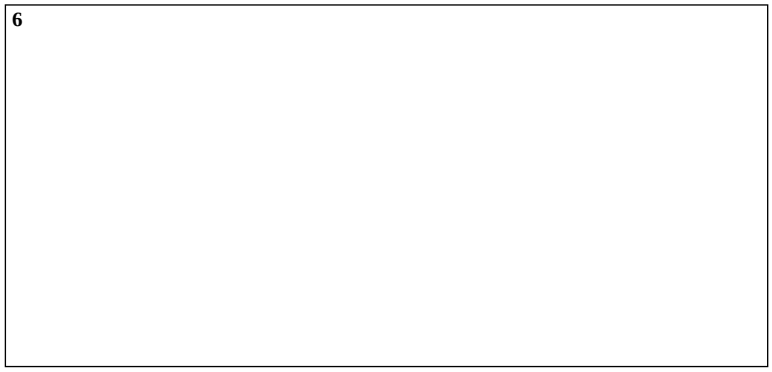


Fig. 7 – Distribution of Vd by groups (the effect of administering STT: on the left, believers with and without STT (c1, c3); on the right, agnostics with and without STT (a2, a4).

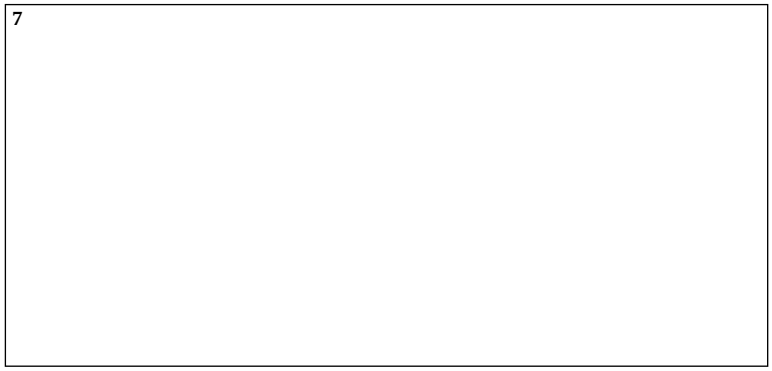
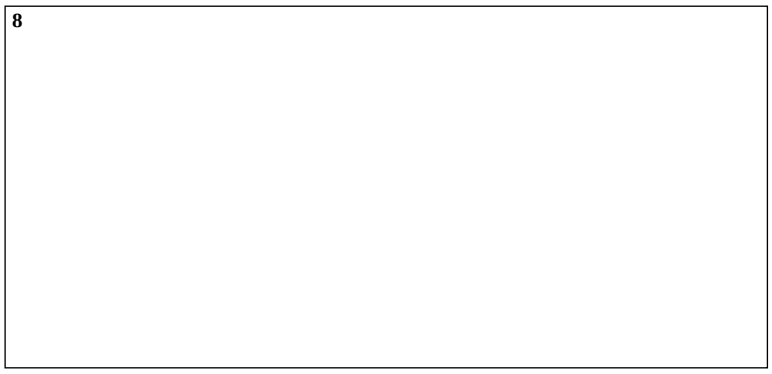


Fig. 8 – Distribution of V1 by groups (difference between believers and agnostics): on the right, believers and agnostics without STT (c3, a4).

Fig. 9 – Distribution of Vd by groups (difference between believers and agnostics): on the left, believers and agnostics with STT (c1, a2); on the right, believers and agnostics without STT (c3, a4).



The mean and the SD of distributions for V1 and Vd in groups c1, a2, c3 a4 are as follows:

Nr. cases	37	23	34	26
	V1c1 5.216+1.134	V1a1 6.304+0.822	V1c3 5.206+1.431	V1a4 6.538+0.706
	Vdc1 2.216+0.787	Vda2 1.609+0.656	Vdc3 1.647+1.125	Vda4 1.269+0.667

(cfr. Notes 3-4)

I) On the basis of the normality test, V1 distributions may be regarded as normal in all four groups. The comparison of the mean in the different distributions by way of the Student t test shows the following. *Table V (V1 Variable).*

II) From the normality test, Vd distributions in the four groups are not normal. But, frequently, in such cases as well a comparison of the mean in different distributions was effected through the t test. The results are as follows. *Table VI (Vd Variable).*

Table V shows the following.

a) Administration of the STT does not significantly change V1 (1-3;2-4;1+2+3+4).

b) The mean value of V1 is significantly different for subjects in groups c and a (1-2;3-4;1+3 - 2+4).

In addition, the following deductions are drawn from Table VI: the mean value of Vd is significantly different for subjects in group c to whom the STT was administered, as opposed to those in group a (2-4), and, obviously, for those in the cumulative groups (1+2) — (3+4).

Consequently, on the average, response to treatment improves with the STT.

Table V (V1 VARIABLE)			
groups	nr. degrees of freedom	t value	significance
1-3	69	0.033	< 5% N.S.
2-4	47	1.050	> 5% N.S.
1-2	58	-3.929	< 1‰
3-4	58	-4.287	< 1‰
1+3 - 2+4	118	-5.932	< 1‰
1+2 - 3+4	118	-0.652	> 5% N.S.

Table VI (Vd VARIABLE)			
groups	nr. gradi libertà	valore t	significance
1-3	69	2.451	< 1%
2-4	47	1.755	< 5%
1-2	58	3.043	< 5‰
3-4	58	1.429	7.5% N.S.
1+3 - 2+4	118	3.120	< 1‰
1+2 - 3+4	118	3.076	< 1‰

Table VII (V1 VARIABLE)		
groups	Z	significance
1-3	0.66	N.S.
2-4	1.148	N.S.
1-2	3.757	< 1‰
3-4	3.759	< 1‰
1+3 - 2+4	5.430	< 1‰
1+2 - 3+4	1.108	N.S.

Table VIII (Vd VARIABLE)		
groups	Z	significance
1-3	2.475	< 1%
2-4	1.717	< 3%
1-2	2.883	< 5‰
3-4	1.926	< 5‰
1+3 - 2+4	3.408	< 1‰
1+2 - 3+4	3.255	< 1‰

The mean value of Vd is significantly different for believers and agnostics if they are administered the STT (1-2), but is not significantly different if the STT is not administered (3-4). On the average, believers respond better to therapy.

With this test, the results of the comparison distribution values for V1 and Vd are as follows. *Table VII (V1 Variable).*

The results of the U test are perfectly compatible with those of the t test for the V1 variable.

As regards comparison with the U test of the Vd distributions for the different groups, the findings below are obtained. *Table VIII (Vd Variable).*

According to the U test, there is a significant difference for all six distribution pairs of the Vd variable, which shifts notably towards higher values in the first group, as compared to the second one.

Analysis of distribution of the two variables, V1 and Vd, shows the following.

1) The STT does not significantly increase the initial pain threshold (as might reasonably be expected), but does significantly improve the results of therapy, with a consequent raising of the threshold of nociperception (cf. Tables V, VI, VII, VIII, groups 1+2 towards 3+4).

2) The basic threshold is higher in believers (cf. Figure 2).

3) There are better therapeutic results in believers than in nonbelievers (cf. Figures 5, 7, 9).

To study a possible difference in VAS variations from one group to another during treatment, a factorial analysis was also done on 120 cases as a further verification.

In a set of curves formed by n determinations there are different shapes. In the curves appearing, factorial analysis two or more curves (factors f1, f2,...) for which every curve in the set is provided by a linear combination of them.

An example with two: c=co+a.f1+b.f2, with *co* indicating the mean curve of the population, where *co* is the same for all; *a* and *b* are the percentages with which the two basic curves contribute to forming curve *c* (weights). N.B.: For mathematical reasons the factors are “orthonormal”

fi*fj=0 if #j

1 if i=j

In a medical and psychological problem, a meaning is often attached to the factor on the basis of the shape of the curve.

In our case the *prime factor* (*) might be termed the “improvement factor” (normalized VAS tending to decrease); the *second factor* (o) may be interpreted as subjects’ reaction to therapy to restore their original state (Table IX).

In the correlation between these two patterns different modalities are obtained for the overall pattern in a given subject.

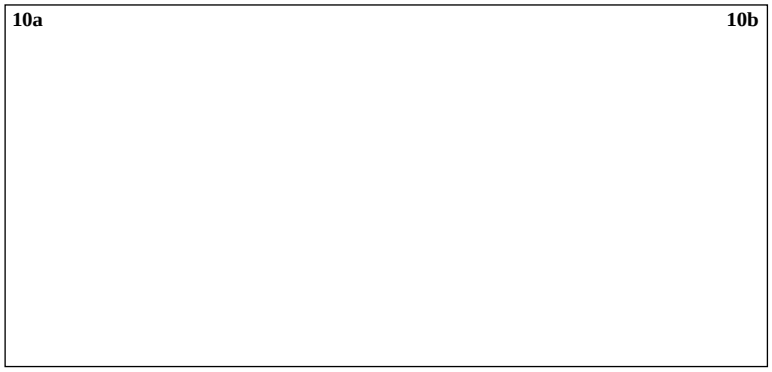


Fig. 10a – Main factors:
1) (*) Improvement Factor
2) (o) Organism Reaction Factor

Fig. 10b – Modes of progression of VAS in believers and agnostics, regardless of initial values.

Table IX

First main factor (*)	
1	.751
2	.563
3	-.221
4	-.615
5	-.604
6	-.486

Second main factor (o)	
1	-.248
2	.227
3	.558
4	.238
5	-.223
6	-.399

In addition, it is possible to separate the quantitative value of the data from the modalities whereby they change during treatment.

From the analysis of VAS data two main factors (Figures 10a, 10b) are obtained; the mean patterns in the six determinations, independently of the quantitative values of the data, were then calculated for the two populations (believers and agnostics).

Examination of these patterns shows that the rapidity of variation decreases in order for the different groups (c1, c3, a2, a4); group c is the one with maximum variation from the beginning to the end of therapy.

Conclusions

In summary, the results of the study are as follows.

1) Believing patients present a higher pain perception threshold (that is, they experience pain less) than do nonbelievers.

2) Groups of believing patients respond better to meditative treatment than do agnostics.

In confirmation of these data, the difference (Δ) between the initial (mean VAS T0a) and final (mean VAS T10b) threshold is 1.784 in group c1, 1.69 in c3, 1.61 in a2, and 1.27 in a4.

Analysis of the difference (Δ) shows that the greatest improvement is found in the group of believing patients subjected to the STT and decreases more and more noticeably in the other groups (believers without the STT, agnostics with the STT, agnostics without the STT).

On the basis of this study the physiopathological mechanism by which the condition of faith modulates perception of the painful stimulus may be explained a) *neurophysiologically,* in terms of the activation of descending inhibitory bands which modulate the conduction of the nociperceptive stimulus, bringing about a reduced perception of pain (R. Melzack and P.D. Wall); b) *neuropharmacologically,* with the release of endorphins, endogenous substances of an opiate nature with analgesic action (J. Hughes et al., 1975; R. Corradetti et al., 1978).[5]

B) Theological Interpretation

This controlled blind study on a group of subjects suffering from chronic painful pathologies sets experimental data before the moral theologian which have been obtained with maximum scientific rigor. Two aspects, above all, attract our attention. The first concerns the difference in both the basic pain threshold and therapeutic results among believers and agnostics. Believers have both a higher basic pain threshold and better results in treatment. The second concerns the difference on the basis of the administration of the reading of a Gospel passage. Daily meditative reading resulted in both raising the pain threshold and improving therapy among believers as well as agnostics.

It follows that whether or not one is a believer and whether or not one reads a passage from the Word of God meditatively have an effect on both the pain perception threshold and the therapeutic effectiveness of a pharmaceutical.

We already know scientifically that a transcendent ethical-religious conviction can activate inhibitory bands in such a way as to prevent entry of the input of painful stimuli or can foster the release of endorphins which, in turn, block receptors for nociperceptive stimuli. Yet—and this is the key point at present—what is the "theological" explanation for this physio-pathological mechanism? I at once point out that I do not intend to debate scientific explanations; rather, I find the denial of entry to nociperceptive input and the blocking of receptors to be a valuable backdrop. Furthermore, mindful of the axiom that gratia non destruit sed perficit naturam—that is, grace does not destroy, but perfects nature—and recalling the thesis that grace has a healing effect, these scientific explanations seem to me to confirm both the axiom and the thesis. I thus structure the theological

explanation into three moments: the ontic unity of the different element constituting man; the stimulating force of the transcendent element of faith; the effect on the basic pain threshold and therapeutic effectiveness.

1. The Ontic Unity of the Different Elements Constituting Man

In speaking of the constituents of the human person, the Old Testament uses three terms: body *(basar),* soul *(nephes),* and spirit *(ruach).* It should be noted immediately that, though signifying different human constituents, these terms still indicate, however, the unity of the human being.

Indeed, the term *nephes*—that is, 'soul'—has nothing to do with the Platonic dichotomy of body and soul, but, rather, indicates that man is a being living in the body. This important anthropological indication is further confirmed in the meaning of the term *basar.* In effect, *basar*—that is, 'body'—is synonymous with "I," "you," etc. *"Mon basar,"* writes one of the leading scholars on this subject, *"is myself, a being of flesh."*[6] Nevertheless, the unity of the constituents of the human being is indicated, above all, by the term *ruach.* In short, man lives only as long as he breathes, but he receives this breathing, this respiration of his, from God in every instant. This is what we read in the account of man's creation: "...Then Yahweh shaped man with the dust of the ground and breathed a breath of life into his nostrils; man thus became a living being."[7]

In his unity, then, man is first of all a religious being. Every man, whether aware of this or not, has a relationship with God as *primary* origin and *ultimate* end. To indicate this existential-religious relation between man and God, *Alpha and Omega,* the Bible uses *precisely* the term *ruach.* In other words, when the inspired authors want to reveal that every man is, above all, a spiritual/corporeal being called to encounter God, they use the term *ruach.* In this indication regarding the human constitution the Fathers of Vatican II grasp man's maximum dignity, writing, "The loftiest reason for man's dignity consists of his vocation to communion with God. From birth on, man is invited to dialogue with God: indeed, he does not exist except because he is created out of love by God and is always conserved by God out of love."[8]

We can draw two conclusions from this theological vision of man. First, man "is not mistaken in recognizing himself to be superior to corporeal things and in regarding himself as more than just a particle of nature or an anonymous element of the human city."[9] Secondly, man does not "live fully according to truth unless he freely recognizes and entrusts himself to his Creator."[10] For this reason, in his interiority man transcends the universe when, turning to his heart—that is, to this deep interiority where God, who examines hearts, awaits him—he decides regarding his destiny under God's gaze. In returning to this depth, man thus recognizes he has a spiritual, immortal soul and does not allow himself to be deceived by fallacious fictions flowing exclusively from physical and social conditions, but, rather, proceeds to touch the deep truth of things itself."[11]

To grasp even more deeply, however, this ontic/religious unity of the different constituents of man, we must reflect on the terms used by St. Paul: *soma* (body), *psyche* (soul), *pneuma* (spirit). With the term *soma,* he indicates the whole man, in his living, vital existential reality in relation to Christ and to the Holy Spirit. He writes to the Corinthians, "Don't you know that your bodies are members of Christ?"[12] "Or don't you know that your body is a temple of the Holy Spirit, who is in you and whom you have received from God?... Glorify God, then, in your body."[13] However—and this is the point of interest at present—the Apostle speaks of a lifestyle of *somatic man* which is proper to him on account of the presence of the Spirit of the Father and Christ in his deepest interiority. Somatic man is made capable of spiritual worship—that is, to offer his body "as a living sacrifice, holy and pleasing to God."[14] In other words, the Spirit of Christ, present in man, gives man's corporeal existence a value for worship which is pleasing to God. Moreover, this presence of the Spirit is, above all, the cause of somatic man's sharing in *doxa*—that is, in the glory of Christ. The man miraculously converted on the road to Damascus does not leave us with the slightest doubt in this regard: "And if the Spirit of the one who raised Jesus from the dead dwells in you, the one who raised Jesus from the dead will also give life to your mortal bodies by means of his Spirit, who dwells in you."[15]

"Pneumatic" man can also lead a life guided by the Spirit and thus shares already in Christ's resurrection, a man who has already wounded all the enemy forces at the root, because he is capable of destroying sin in his heart by virtue of the presence of the Spirit of Christ. Indeed, "Christ's resurrection mortally wounded, by way of grace, all the destructive forces of sin and death enclosed in man's heart which corrupt the world and are the cause of every sort of servitude and slavery."[16] The *spiritual man,* then—and this is the point to be stressed—has, according to St. Paul, an inner patrimony in his heart which is able to overcome all evils at the root, including those of suffering and death.

At this point I am spurred to note that this theological anthropology is in full harmony with the most secret natural aspirations of the human heart because, in addition to defending the dignity of the human person, it restores hope to those now despairing of a higher destiny. This harmony becomes even truer and more certain when we accept the fact that all creation is waiting "impatiently for the revelation of the children of God... and

hopes to be freed as well from the slavery of corruption, to enter into the liberty of the glory of the children of God."[17]

That is why, since no man can entirely flee from the enigmatic questions of life, death, guilt, and pain, this Gospel discourse in defense of dignity and the hope of the heart invites every man—but the sick, in particular—to reflect deeply. In effect, dignity and hope encounter their ground precisely *in God* and their perfection, *from God* man receives the gifts of intelligence and freedom, but, above all, because *by God* he is called to communicate with the Divinity as a son and to share in God's own happiness."[18] The unitary ontic/religious structure of every human being, then, from a theological standpoint, has a great deal to do with illness, for it is proper to administer to the sick in particular a Gospel passage to be read and meditated on. Indeed, "only God gives a full, certain response; He who calls man to higher thoughts and more humble seeking."[19]

Of course—and this leads to the second and principal moment in theological explanation of the subject of pain—accepting a response through meditated reading of the Word of God presupposes an attitude of faith.

2. The Stimulating Power of the Transcendent Element of Faith

What God wanted to manifest and communicate about Himself and the eternal decrees of his will regarding the salvation of men absolutely transcends the understanding of the human mind.[20] In other words, and more precisely, "*The obedience of faith*, whereby man abandons himself entirely to God in a free act, should be given God, who reveals (cf. Rm 16:26; Rm 1:5; 2 Co 10:5-6), by offering 'the full homage of the intellect and the will to God, who reveals,' and assenting voluntarily to the revelation given by Him."[21] Precisely because faith is a transcendent gift, man, in order to be able to offer the obedience of faith, needs "the grace of God, who anticipates and assists, and the inner aids of the Holy Spirit to move the heart and turn it to God, to open the eyes of the mind, and give 'everyone sweetness in consenting to and believing in truth.'"[22] I shall add—and this is quite important for theological explanation—that the Holy Spirit Himself continually perfects faith by means of his gifts so that the intelligence of revelation will become deeper and deeper.[23] Faith, when conceived as obedience, thus connotes a dialogical structure: God addresses man, and man listens and responds.

Now, in the present blind study, faith as a transcendent element has the function of measuring possible variations in both the pain threshold and the therapeutic result of a pharmaceutical. Precisely for this reason a test was administered presenting God as the source of love, not only because He is Love from which all love originates, but—and this is much more important for the sick reading and meditating—also, and above all, because He reveals that those who remain in love dwell in God and God dwells in them. Meditation on this mutual divine and human dwelling in love seeks to foster an existential attitude in the sick of trusting abandonment to the love of God—by way of the theological virtues—which will result in increased endurance of pain and greater effectiveness of medicines.

Before continuing the theological explanation, I shall note, along with the Italian bishops, the situation of profound "subjective" crisis in this regard. "The phenomenon of secularization in which today's Christians live not only places their faith in a state of crisis, but—perhaps in an even more profound way—wounds its theological presence, for the present and future life. Indeed, the greatest and most dramatic realities of man's life, such as suffering, illness, and death, do not escape the crisis brought on by secularism; rather, precisely in regard to this reality a change in mentality and sensibility is being effected which eventually damages the Christian meaning of human existence."[24]

"Invoking God as a 'therapist,' as the One who can accomplish things beyond the power of human intelligence, seems repugnant and superstitious to men who now tend to regard themselves as the sole arbiters of their destiny."[25]

And yet a person reflecting on Christ's compassion for the sick will not find it either repugnant or, even less, superstitious to resort to Him as a physician. It suffices to open the Gospel and follow Him as He traverses Galilee, healing and casting out demons. There recurs in Jesus' life as a genuine refrain his bringing relief to those suffering and those in a state of indigence. The evangelist Mark tells how Christ arrived in the region of Gennesaret and, as soon as He had disembarked, "the inhabitants recognized Him and, as He traveled through that whole region, they began to bring Him the sick on their stretchers wherever the people realized that Jesus was present. And in all the places where He arrived, in the villages, cities, and towns, they set the sick down in the squares and begged Him to let them touch at least the hem of his cape. And all those who touched Him were healed."[26] These healings were the Messianic credentials announced by the prophet Isaiah: "Say, 'Take heart!' to the downhearted. Do not fear: your God is here... He is coming to save you. They eyes of the blind will then be opened, and the ears of the deaf will be unblocked. The lame will then leap like a hind; the tongues of the mute will cry out in joy...."[27] "Christ's compassion towards the sick and his numerous healings of the infirm of every kind," the *Catechism of the Catholic Church* specifies, "are a clear sign of the fact that 'God has visited his people' (Lk 7:16) and that the Kingdom of God is near."[28]

These are not, however, magical interventions—and this is the basis for the theological explanation—for Christ always requires an attitude of faith. Indeed, healing, as He Himself states, is primarily the effect of the faith of the sick. "One day a woman who had been suffering from a flow of blood for twelve years came up behind Jesus through the crowd and touched his cape. For she was saying, 'If I can manage just to touch even his robe, I will be healed.' The source of the loss of blood dried up instantly, and in her body she felt she had been healed of the affliction. Jesus at once realized that power had gone out of him and, turning to the crowd, asked, 'Who touched my robe?' His disciples replied, 'You see that the crowd is pushing in against you and you ask, 'Who touched me?' But Jesus looked around him to see the woman who had done this. The woman, frightened and trembling, quite aware of what had happened, then came to cast herself at his feet and told him the truth. Jesus said to her, 'Daughter, your faith has saved you: go in peace and be healed of your infirmity.'"[29]

Beyond all doubt, Jesus' reaction brings out the fact that the contact between the woman and himself was not of a physical order, as the disciples thought, but of a "transcendent" order—that is, involving "faith", as He Himself affirms. This woman entered into her deep interiority, where she transcended the universe and where Christ (God), who was examining her heart, was speaking to her so that she would decide about her destiny. In her inner depths the faith dialogue took place which brought the woman to exclaim, "If I manage to touch even his clothing, I will be healed." And so it occurred. Indeed, Jesus said to her, "Daughter, your faith has saved you.... Be healed of your illness." It is thus very clear in this case that the cause of healing was the woman's faith. Jesus Himself provided the most convincing testimony of it when He said he had felt touched by the woman's faith on realizing a power had gone out of Him.

The fact that faith, as a transcendent element, is decisive for a divine-human encounter facilitating a therapeutic result in the suffering patient is consistently proved in the case of the healing of a possessed boy. After having reproached everyone for incredulity, Jesus asked to have the boy brought to Him. At the sight of Jesus, the evil spirit convulsively shook the boy. When Jesus asked how long this had been going on, the boy's father replied, "Since he was a baby." He then addressed Jesus as follows: "If you can do something, help us out of mercy!" "If you can!" Jesus answered. "Everything is possible for those who believe!" The boy's father immediately cried out, "I believe. Come to the aid of my lack of faith...." Jesus commanded the unclean spirit as follows: "Mute and deaf spirit, I order you to depart from him and never return...." The boy seemed to fall dead. But Jesus, grasping his hands, raised him up and he remained standing.[30] To avoid misunderstandings, two points should be brought out with great clarity. The first is that Jesus did not want to heal all the sick, much less remove illness and death from man's earthly life. "According to the Christian faith, illness traces its origin to the corruption brought into the world by sin, in addition to the finitude of the human creature."[31] However, it is precisely this link between sin and illness which explains Jesus' very special attention to the sick. The Italian Bishops state, "Jesus, who came to take away the sin of the world, thus displayed very special attention to the sick and manifested his infinite mercy towards them, freeing those who turned to Him with faith or were brought to Him with trust from infirmities."[32]

The second point stresses that Jesus responded to the sick person's attitude of faith with a miraculous action. This does not, however, diminish the forcefulness of the theological explanation, but, rather, confirms it, particularly because every miraculous healing from physical maladies possessed the value of being a sign of and prelude to liberation from sin, which was precisely the cause of death and illness.[33] Faith, then, is clearly the force which deals with illness at its root. Therefore, theological explanation rightly centers on the transcendent attitudes of theological faith and trust regarding divine compassion towards the sick—factors able to raise the basic pain threshold and increase the therapeutic effectiveness of the administration of medicines. At this point we are still left to explain how these transcendent elements, stimulated by prolonged meditative reading of a Gospel passage, influence the physiopathological mechanism without the occurrence of a miraculous action.

3. The Transcendent Influence on the Basic Pain Threshold and Therapeutic Effectiveness

To facilitate comprehension of the points below and bring out a logical connection, I shall summarize what we have stated thus far.

From the tables on Average Variation (VAS) in the four groups there emerges most evidently the influence of belief

and meditative reading on the basic pain threshold and the effectiveness of pharmacological therapy.[34] In attempting to explain such experimental data from a theological standpoint, as an introduction I have analyzed first the ontic unity of the elements constituting every human person and then the stimulating power of the transcendent element of faith. On this basis I shall now deduce some conclusions to explain the variations in pain we have indicated: mutual influence among the different constituents and the dominant influence of the spiritual constituent on the person's whole being. Of course, we are mainly interested here in the transcendent influence on persons suffering from chronic painful pathologies.

The conclusion explaining mutual influence is based, above all, on the Pauline meaning of the word *sarx*, or flesh. By this term the Apostle indicates concupiscence—that is, all intense forms of human desire opposed to the dictates of human reason. Concupiscence is thus identified with the flesh's opposition to the spirit.[35] The flesh "produces disorder in man's mental faculties and, without being a sin in itself, inclines man to commit sin."[36]

It is thus clear that "there already exists a certain tension in man, as a *compound* being, *spirit and body*. A certain struggle takes place between the tendencies of 'the spirit' and those of 'the flesh.' But this in fact pertains to the inheritance of sin; It is a consequence of it and at the same time a confirmation. It forms part of the daily experience of spiritual combat."[37]

Now, precisely as a result of this spiritual combat between the spirit and the flesh, the *carnal* man is called to become the *somatic* man—that is, the man who *is* a pneumatized body or an embodied spirit. The Apostle reveals this to us when he writes to the Galatians: "But if you let yourselves be guided by the Spirit...are charity, joy, peace, longanimity, benignity, goodness, faithfulness, meekness, and temperance. There is no law going against this kind of action. Those who belong to Christ have crucified the flesh with its passions and desires. If we live by the Spirit, let us conform ourselves to the Spirit."[38] This is how St. Paul brings out the mutual "existential" influence among the ontic constituents of every human person, both negative, in terms of the evil of "carnalization," and positive, in terms of the good of "spiritualization."

I note at once that this dynamic is the work of Christ and of his Spirit, above all. St. Paul also reveals this to us:

"...All of us once lived according to our carnal passions as well, following the desires of the flesh and of wicked thoughts, and, on account of our natural inclinations, we were thus an object of wrath in the same way as others. But God, rich in mercy, because of the great charity with which He has loved us—dead as we were by virtue of our sins—gave life back to us with Christ—you have been saved by grace—and raised us up with Him and caused us to sit in the heavenly regions, in Christ Jesus, to demonstrate in the ages to come the superabounding wealth of his charity, through his goodness towards us in Christ Jesus."[39] For St. Paul, then, it is not a matter of discriminating against and condemning the body, which with the spiritual soul constitutes man's nature and personal subjectivity, but to pay attention to works—or, rather, stable dispositions, virtues and vices—which are morally *good or evil*, which are fruits of *submission... or of resistance... to the salvific action of the Holy Spirit*.[40] But we have now come to the concluding explanation of the stimulating power of the transcendent element of faith and the consequent decisive pneumatic influence on the physiopathological mechanism.

Indeed, it is through the action of Christ and of his Spirit that we are now able to live as somatic man in the works of the Spirit against the flesh, precisely by means of faith. "For," as St. Paul specifies, "by grace you have been saved, by means of grace, and not through yourselves—it is a gift of God; not by works, so that no one will have a reason to become proud. We are, in fact, his work, created in Christ Jesus with a view towards good works, preordained by God so that would practice them."[41] In short, whoever lives by the Spirit also walks according to the Spirit.[42]

In other words, "in Christian life, the Holy Spirit does his work by mobilizing one's whole being, including sorrows, fears, and moments of sadness, as is evident in the Lord's Agony and Passion."[43] This explains why Christians, though, like all men, aware of the dramatic scope of illness and observing its complexity, "but enlightened and supported by faith, are in a position to penetrate more deeply into the mystery of pain and bear it with more virile fortitude."[44] It is quite clear here that faith, as a transcendent element of light and support, exerts a twofold influence: as light, it makes people capable of entering into the mystery of pain and, as support, it enables pain to be borne in a more virile manner.

At this point I shall observe that it is precisely these influences of faith which the Church professes when she offers believers the special sign of the merciful love of Christ

for those whose state of health is seriously compromised by illness or old age, regarding whom the special gift of grace is represented by the sacrament of the anointing of the sick. In celebrating this sacrament, "the whole church recommends the sick to the suffering and glorified Lord that He may lighten their afflictions and save them; indeed, she exhorts them to unite themselves spontaneously to the passion and death of Christ, so as to contribute in this way to the welfare of the people of God."[45] I point out that the *Catechism of the Catholic Church* explicitly reaches the above—mentioned twofold influence of the faith gift of the Holy Spirit. "The basic grace in this sacrament is a grace of comfort, peace, and courage to overcome the difficulties proper to the state of serious illness or the fragility of old age. This grace is a gift of the Holy Spirit which renews trust and faith in God and fortifies us against the temptation of the devil—against the temptation of discouragement and anguish in the face of death."[46]

In this way Christ, in tile and space, through the power of his Spirit, goes on assisting every person and every believer, whom He stimulates in some degree by means of the transcendent gift of faith, the most intimate constituent of the person's being—that is, the *ruach* or *pneuma.* With this stimulus of faith the Spirit of Christ seeks to heal not only the soul of the sick, but also, if a benefit is to be obtained therefrom, the body. This influence of the faith proves to be evident in the sacrament instituted *ad hoc* by Christ and announced by St. James. What Christ, "the physician of the body and the spirit,"[47] instituted is in fact announced by St. James as follows: "If anyone is sick, let him call for the presbyters of the Church and let them pray over him, after having anointed him with oil, in the name of the Lord. And prayer uttered with faith will save the sick person: the Lord will raise him up again..."[48]

To avoid misunderstandings I will specify that we are dealing here, it is true, with the specific rite instituted by Christ for the sick, but this in no way diminishes the probatory value of our theological explanation; rather, this sacramental rite represents only the maximum and not the inly aspect of the influence of faith and theological trust on pain. The Church, as her *Catechism* affirms, "believes in the vivifying presence of Christ, the Physician of souls and bodies. This presence is particularly at work in the sacraments and in a uniquely special way in the Eucharist, the bread which gives eternal life and to whose link with the health of the body St. Paul refers."[49] The Apostle alludes to those who, on eating and drinking, do not discern the body of the Lord.[50] In any case, and this is what I want to affirm, Christ's invitation, addressed to his disciples, to "heal the sick" is not limited to the celebration of the anointing of the sick, but extends to all care of the sick. Therefore, as the *Catechism* further specifies, the Church seeks to carry out this task which she has received from the Lord through both the care provided patients and the intercessory prayer with which she accompanies them.[51]

Now, and this is of the utmost importance, in this study we have wished to do the work of "healing the sick," precisely by way of administering a meditated reading of the Word of God as well. We wanted to stimulate faith in the vivifying presence of Christ, the Physician of souls and bodies and, as a result, scientifically verify the transcendent influence of the power of faith on pain. The tables clearly bring out the real variation in the four groups involving the basic threshold and the effectiveness of therapy. This "scientific" evidence, in the light of the faith of the Church, where the vivifying Spirit of Christ is present in the Word of God, may be validly explained "theologically" in terms of the ontic-religious unity of the constituents of the human person and the stimulating power of the transcendent element of faith.

If we compare the "scientific" to the "theological" explanation of the VAS Average Variation in the four groups, I am convinced that we are faced with a confirmation of the "perfecting and healing" relationship of grace to nature. The ontic-religious unity of the different constituents clearly explains not only their reciprocal influence, but, above all, the dominnant influence of the pneumatic constituent on the somatic one. The grace of faith has an influence on the pain threshold, by both closing the gate to nociperceptive inputs and blocking the receptors for the perception of pain stimuli through the release of endorphins.

To give this interpretation even greater weight I shall refer to the Church's teaching on man in Paradise. In interpreting the symbolism of the biblical language authentically, the Church teaches that all the dimensions of man's life were augmented by the infusion of the original grace of sanctity, whereby "as long as he remained in divine intimacy, man was not to die or suffer. The inner harmony of the human person, the harmony between man and woman, and, finally, the harmony between the first couple and all creation constituted the condition

called 'original justice.'[52] Therefore, the infusion of grace into the soul of the first man was such as to prevent his body, though mortal, from dying and keep it, though capable of suffering, from actually suffering. The spiritual soul was so reinforced by God's grace that it prevented the material body from dying and suffering. Now a question arises which is certainly not rhetorical: Why can't faith reinforce the soul in such a way that it has an effect on the suffering body, raising its pain threshold and improving its recovery of health? The affirmative reply in the theological explanation assumes even greater persuasive forcefulness if we consider that the vivifying presence of the Spirit of Christ is a guarantee of the resurrection of the body because He is the author thereof. If the infusion of the grace of paradise can keep man's "mortal, suffering" body from dying and suffering, all the more is the power of faith in the presence of the vivifying Spirit—stimulated by a meditative reading of his Word—capable of raising the pain threshold and improving therapeutic effectiveness in the body, which will indeed die, but will rise again, immortal, precisely by means of the Spirit of Christ, who dwells in us.

Conclusion

On the basis of the foregoing, we are able to affirm the following points.

1) Faith produces an ethical effect in each individual whereby the spiritual self is reinforced and rediscovered; this ethical value is so elevated and autonomous that it raises the pain threshold in believing patients.

2) All individuals, even if agnostic or indifferent to ethical-religious formulations, are stimulated, in being shaped by God, as entities in the image and likeness of God, even if unaware of Him, by references of a transcendent kind such as readings, with the meditation of a passage recalling a superior presence.

3) This confirms that faith, stimulated by a meditative reading of the Gospel, promotes a better experience of illness in general and of the state of pain in particular.

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Notes

[1] Patients were given the following text.

"God is love, and whoever remains in love remains in God and God in him. Love comes to its perfection in us when we can face the Day of Judgment fearlessly, because even in this world we have become as he is. In love there is no room for fear, but perfect love drives out fear, because fear implies punishment, and whoever is afraid has not come to perfection in love. Let us love, then, because he first loved us. Anyone who says, 'I love God' and hates his brother is a liar, since whoever dose not love the brother whom he can see cannot love God, whom he has not seen. Indeed, this is the commandment we have received from him, that whoever loves God must also love his brother. Whoever believes that Jesus is the Christ is a child of God, and whoever loves the father loves the son. In this way we know that we are God's children, when we love God and keep his commandments. This is what the love of God is: keeping his commandments. Nor are his commandments burdensome, because every child of God overcomes the world. And this is the victory that has overcome the world–our faith."

[2] See J. SCOTT, E.C. HUSKISSON, *"Graphic Representation of Pain,"* in *Pain*, 2 (1979), 175.

[3] SEE S. WILCOXON, *"Individual Comparisons by Ranking Methods,"* in *Biometrics Bulletin*, 1 (1945), 80-83.

[4] See H.B. MANN and D.R. WHITNEY, in *Ann. Mat. Statist.*, 18 (1947), 50-60.

[5] R. CORRADETTI and G. PEPEU, *"Le endorfine,"* in C.A. PAGNI, P. PROCACCI, V. VENTAFRIDDA (eds.), *Il dolore: problemi di fisiopatologia e terapia* (Verona: Edizioni Libreria Cortina, 1978), pp. 83-94.

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[8] *Gaudium et Spes*, Pastoral Constitution on the Church in the Contemporary World, no. 19 (hereafter cited as *GS*).

[9] *GS*, no. 14.

[10] *GS*, no. 19.

[11] *GS*, 14.

[12] *1 Co* 6:15.

[13] *1 Co* 6:19-20.

[14] *Rm* 12:1.

[15] *Rm* 8:11.

[16] B. HONINGS, *Una irenologia della chiesa per il mondo di oggi* (Rome: Edizioni Catena, 1993), pp. 205-206.

[17] *Rm* 8:19-21.

[18] *GS*, no. 21.

[19] *Dei Verbum*, Dogmatic Constitution on Divine Revelation, no. 6 (hereafter cited as *DV*).

[20] *DV*, no. 6.

[21] *DV*, no. 5.

[22] *Ibid*.

[23] Cf. *Ibid*.

[24] Italian Bishops' Conference, *Evangelizzazione e sacramenti della penitenza e dell'unzione degli infermi*, Collana-Documenti CEI, no. 11 (Turin: Elle Di Ci, 1974), no. 118.

[25] *Ibid*., no. 123.

[26] *Mk* 6:55-56.

[27] *Is* 35:4-6.

[28] *CCC*, no. 1503.

[29] *Mk* 5:27-34.

[30] *Mk* 9:20-27.

[31] Italian Bishops' Conference, *Evangelizzazione...*, no. 132.

[32] *Ibid*., no. 133.

[33] *Ibid*., no. 133.

[34] See the appendix above.

[35] He writes, "I tell you, then: walk according to the spirit and you will not risk satisfying the desires of the flesh. The flesh, in fact, has desires contrary to the spirit, and the spirit has desires opposed to the flesh: they are in conflict with each other, in such a way that you do not what you would like to" (*Ga* 5:16-17).

[36] *CCC*, no. 2515.

[37] *Ibid*., no. 2516.

[38] *Ga* 5:18 22-25.

[39] *Eph* 2:3-7.

[40] John Paul II, Encyclical *Dominum et Vivificantem*? 55.

[41] *Eph* 2:8-10.

[42] Cf. *Ga* 5:25.

[43] *CCC*, no. 1769.

[44] Italian Bishops Conference, *Evangelizzazione e sacramenti della Penitenza e dell'Unzione degli Infermi* (Turin: Elle Di Ci, 1974), no. 131.

[45] *CCC*, no. 1499.

[46] *CCC*, no. 1520.

[47] *Constitution on the Sacred Liturgy*, Second Vatican Council, no. 5.

[48] *Jm* 5:14-15.

[49] *CCC*, no. 1509.

[50] *1 Co* 11:29.

[51] Cf. *CCC*, no. 1509.

[52] *CCC*, no. 376.

Technology and Human Dignity

I want to begin with a question: Why are there so many cases today of dehumanization, indifference, and even violations of patients' rights?

The answer lies in the loss or lack of an "ideal" in our profession, of the ideal of serving the ill, with a rejection of what goes beyond mere healthcare functions and activities.

Saint-Exupery, in referring to today's world, said, "Every human sentiment is ridiculed, and men do not want to be awakened to the life of the spirit." This perfectly applies to our hospital environment—we pay attention only to technological and scientific advances, to the work in itself, to policy. Our mentality is getting selfish, utilitarian, economic, and calculating.

That is why the concept of "serving the sick" has lost value. Even more, all its human significance has been removed—it is just professional activity or technical service which must be carried out because it has been mandated, and in the time allotted we turn into robots whose dominant refrain is "That's not my concern."

Our vocation is highly esteemed for its value in dedication to the sick. This inclination is a gift of God to benefit the ill, an excelling ministry of "Charity," a genuine sacred ministry, as Pope Pius XII termed it.

This gift must be accepted with gratitude, in the knowledge that care of the sick represents a mission and ministry for the great cause of the Gospel and the Kingdom of God.

We must travel along our road responsibly, freely, and dynamically and play our part in the hospital setting as agents for change, not only in terms of scientific and technical training, but as regards augmenting humanity in medicine and nursing.

It is stimulating to speak of the broad humanistic dimension, which cannot be dealt with in all its scope. To speak of our identity necessarily implies talking about our task and our mission. To speak of our convictions and values also implies linking them to commitment in conduct, in a humanism which is all the more profound and impassioned the greater the limitation imposed by a demanding and unilateral scientific education is.

Humanism, together with the cultivation of science, is what protects both patients and ourselves. To be a humanist does not mean to be goodhearted, though the doctor and the nurse should be; rather, it means first of all that one has acquired very deep culture sharpening one's sensitivity in order to see the sick sympathetically, has purified one's judgment in order to seek to understand them in their virtues and deficiencies, and has elevated one's life motivation so as to be prompt in serving and helping them.

Humanism is not a luxury or a refinement of the scholar. Humanism means culture, understanding of man in his aspiration and afflictions, evaluation of what is good, beautiful, and just in life. Culture is the scale of values making man seek—along with good, beauty, and justice—with the attitude of someone in love all that perfects knowledge and ennobles life.

It will be hard for the multidisciplinary health team to offer the understanding, security, and support patients desire and need unless humanistic culture is developed.

Roussel Dick says, "To be sick is to be strange, lacking in vigor, debilitated by an absence of help, and disturbed by betrayed confidence—a stranger among strangers. It is to endure the uncertainty of a diagnosis, be the prisoner of one's own loneliness, unassisted, chained to disablement, and find it hard to face life when bound to the threat of death."

Patients trustingly place themselves in the hands of the health team. To disappoint this trust, disdain patients' emotions, and care for them in a cold, distant manner—if not with treatment reflecting a lack of interest—is to leave them helpless.

If we were more deeply familiar with this mysterious world of patients, we would rediscover that *being* with patients is more important than *acting* on their behalf. Consequently, in this world of action, the interdisciplinary health team of our times not only requires training based on the scientific knowledge demanded by modern technological advances, nor can it be satisfied with being just technician-scientists, but must involve persons who learn each day to be sensitive to human pain.

Like a catalyzing effect, humanism, when projected on science, invites man to flee from selfish isolation and pushes him to work nobly in collaboration. We thus form the health team, with a single ideal: "the patient." The doctor-patient (and nurse-patient) relationship is an eminently human relationship. Someone suffering and asking for help from another who hastens to offer it, bringing his knowledge and experience into play.

Science is necessary; it makes us strong, but not better. A humanistic spirit appreciates what relates to science and knows that beyond discoveries, advances in the field of medicine, physics, and chemistry, are patients' psychic reactions, anguish, and suffering. For a culture divorced from life and a humanism with no concern for

man's problems are inconceivable.

Contemporary man dominates or tries to dominate nature; he is dynamic and open to action—and we are proud to belong to this technological period of major scientific advances.

But I ask myself the following questions.

What impact do current scientific and technological advances have on patients?

Is medicine more effective, or are patients made to suffer more?

Do we avail ourselves of machines to look after patients better, or do we instead take care of the machines more than patients themselves?

Scientific and technological advances cannot and must not be halted; the health team must know and appreciate the great usefulness of teamwork, but also know that their proper use or their abuse will turn them into effective help or harm to patients; machines can do a lot, but never can they understand patients' suffering, tensions, or emotions. No matter how precise they are, they can never replace direct observation of the patient by a trained professional, for whom, furthermore, the subject under observation is, above all, a suffering human being. For, no matter how mechanized and technified the medicine of the future is—and it will be to a degree we can barely imagine—clinical medicine and nursing and the doctor (or nurse)-patient relationship will never disappear. The machine will never triumph over man.

Whoever overlooks the patient, whoever fails to discover a person in his totality has not achieved his own personalization, has not attained his own unity, has not matured humanly; when we are capable of loving ourselves, of respecting ourselves, then we are also able to love people, serve people, especially sick people—not people as an abstraction, but flesh and blood people who work, suffer, dream, and hope, people of all races, creeds, and latitudes.

In our time, the main objective of the hospital is to offer delicate, humane, and integral care, where the patient is not a number, an assignment to a doctor, or an illness, but a "person."

May patients be the focus of our attention so that they can receive not just scientific, but also human answers.

We need to create hospitals where the sick will receive not only the most effective medical care, but also the warmth of sympathy and human aid.

Cold and impersonal attention is not enough in our relation with the sick, not matter how scientific and effective it may be. It is true that, most of the time, when an illness becomes protracted or aggravated, the sick need to hold on to a hope. That hope is the trust they place in the health team by virtue of its knowledge, prestige, and, above all, the spirit of sympathy in which it cares for them.

The hospital must be a place where the sick find the warmth of sympathy and human assistance. A place to heal, to revive, as the rights of the sick demand. It should be a place where one's home is at least partially reflected. We must be convinced that all the science of the healthcare team does not suffice to warm up the atmosphere surrounding a patient unless one puts one's heart and soul into it.

The sick ought to encounter a haven of peace where people reach out to people.

It is therefore essential for the hospital staff welcoming them to be sufficiently humane to make them feel at home—that is, accepted as they are, understood and assisted in their basic needs. This is possible if we are consistent with our ideal. An ideal directing our lives towards higher realms and inviting us to advance further and further, to serve better and then share all the spiritual knowledge and wealth life offers us, doing so without haggling or selfishness, feeling the noble function of giving, because only one who gives is rich and the only strong ones are those capable of dedicating themselves to offering high-quality health care which is effective, safe, and well-planned

by way of two basic virtues: first, knowledge; second, service.

Knowledge is absolutely indispensable for effective care, as is service in increasingly useful cooperation towards treatment, cure, and rehabilitation of those suffering. Cold, inhuman, and aloof attention to patients only augments their solitude and spiritual suffering. Patients are not amorphous or experimental flesh, but imprecating pain, humble longing to hear a friendly voice and a consoling word. Only in this way can the solitude of those undergoing the physical suffering of a malady and the moral suffering of abandonment and isolation become bearable.

Humanism is indispensable for us since without it we cannot live out our humanizing mission at all.

We must strive to be dynamic agents for humanity in medicine, to promote life, hope, and curing through action manifesting that relationships, communication, authority, emotivity, and feeling—whatever is experienced in the hospital—are oriented towards the sick, especially towards their welfare.

We have to take up culture as a humanizing process and preparation in such fashion that it enables us to know and observe the values governing individual conduct by way of attitudes, interests, and dispositions.

The values of ethics, humanism, professional training, and service must be stressed in our field.

The satisfaction we ought to expect is that of being health professionals with the privilege of relieving pain, providing consolation, support, hope, and love, really bearing witness to our commitment, with all its consequences.

We must cultivate a humanism rooted in deep faith leading to joyful, serene hope in a framework of limitless love.

Let us cultivate our minds and spirits as a health team. The more the present-day world throbs with anguish, tensions, and pain, the more it should draw us towards the source of peace, light, and love. From this source we drink the stimulus not to divorce scientific knowledge from culture and ongoing reflection about the timeless subjects regarding conduct—duty, love, and goodness—and thus to elevate the soul in the face of the harsh moments of suffering, pain, anguish, and death itself, to do our duty in the area we ourselves have chosen, not in a cold way, however, but in a human one. For life is not duty—it is charity.

The period when nurses were the servants of doctors is over. They no longer are. They are now faithful and capable co-workers who are intelligent and better able to make decisions. Our dedication, observations, and actions will often determine the treatment selected and the utility of the precious moments when patients are saved or lost. We know we must divide our time among patients, the team, research, teaching, and updating, for we have responsibilities today that we did not have before. Today we do not just obey—we act and are fully integrated into the multidisciplinary team in a vortex of high technology.

The challenge we face appears in the following fields where we are active.

Outpatient activity includes teaching for disease prevention, hypertension clinics, the use of anticoagulants, etc. Primary care is provided in our Institute.

In emergency care, attention is provided in the absence of a physician, with the timely application of life-saving measures.

In the coronary unit, we observe monitors, interpret electrocardiograms, oversee patients on whom angioplasty will be carried out, and deal with the treatment of coronary fibrinolysis.

We work in hemodynamics, in heart operations—coronary angioplasty, valvuloplasties, the closing of arterial ducts, electrofulguration—and in the handling of sophisticated electrobiomedical equipment.

In the operating room, we work with anomalous patterns producing arrhythmias such as that of Wolf Parkinson White, and the surgical treat-

ment of complex congenital cardiopathies.

In the perfusion service, we work with the heart-lung pump.

In surgical intensive therapy, we provide postoperative care, handle electromedical equipment, computers, monitors, ventilators, and the intra-aortic contrapulsation ball.

In pediatrics, we care for children with complex congenital cardiopathies.

In cardiopneumology, we work with spirometric studies, in the medical/surgical care of patients, and in ventilation.

In nephrology, for both conventional and terminal patients, we offer both psychological and technical support for advanced renal insufficiency.

In cardiac rehabilitation, nurses interact with patients in the rehabilitation process, which involves a physical dimension, with supervised exercise sessions, and a psychological and social one, with group therapy, along with demanding efforts in secondary prevention.

In the physiology laboratory, heart protheses are made from bovine pericardium.

In experimental surgery, we prepare protocols for scientific research along with physicians.

Today we are professionals of higher standing, but the higher this is, the more marked and profound our responsibility is, without neglecting the fact that in these dehumanizing times we must fill the gap in our inner dimension as persons and provide the attitude of humanity which the sick more and more insistently expect from us today.

Just as with academic backing, it is vital to ensure a sense of ethics and humanism; true education cannot exist without a solid moral mainstay—along with love for wisdom, dignity in conduct, uprightness, and humanity: the actions which must inspire our lives. The world today needs us to be not only strong, but better, and this is attainable only by way of culture. With culture we obtain human understanding, an upright spirit of justice, and a wholesome attitude towards helping others.

Today spatial distances have been shortened, but distances between hearts have grown, and society is getting colder; men seem solitary and strange; the sense of the most humane and transcendent values is being lost. The gap is widening between man and his brother man.

Those of us working to promote and preserve health must thus be truly sensitive to all human pain.

That pain humanizes us and also makes those one undergoing it more humane—if we are able to orient them. In this very element patients find in their pain a positive aspect for transformation which gives their lives meaning. They struggle for life and encounter redemption. A major service is offered and humanization takes place. Wherever the health team tries to heal people in a truly humane way, there is a proclamation of the freedom which, by way of sick bodies and expert hands, unites human beings fraternally in pursuit of a better world.

Are we sure we possess the necessary culture, generosity, and sensitivity to approach human beings in danger requiring our help—or do we instead take part coldly in stripping them physically, psychologically, socially, and morally?

The current world calls for the presence of a multidisciplinary team—the kind, however, that is not afraid or opposed to the progression of history, for it lives out the commitment of freedom grounded in faith. A freedom which does not bind, but enables people to face life prophetically and encounter those not wanted to be crushed by wretchedness, with the aftermath of illness, decline, and death.

At present the multidisciplinary team and women religious, joined in the same ideal, follow the paths now existing in the struggle to obtain the precious gift of health for our people, with an ever greater need for understanding, sensitivity, and goodness imbued with the charity which is Love.

In order for the practice of our profession not to be just the performance of tasks, of technical functions, but, rather, an authentically human service of

generous dedication, personal closeness, and respectful, attentive accompaniment, what values, motivations, and intentions are needed?

The only thing necessary is a universal, noble value motivating and generating attitudes not limited to what ought to be done out of justice, but extending beyond to offer all the concrete goods which patients need—that is, a life-giving value unfolding a dynamic embodied in the real hospital situation.

This value or principle inspiring and animating authentic hospital care is *love*. As Pope Paul VI said in referring to the world, "The world—and, for us, the little world of hospitals—is sick not because of a lack of resources, but because of a lack of love. The only way to remedy this is to increase the degree of love."

"Some additional heart," as Bergson said, is thus required—a change and renewal of heart. "More heart in one's hands," St. Camillus would say. A style of diligent, humane attention to the sick arises from within, from love. To improve service is not a spontaneous event, but entails gaining awareness, a process of interiorizing, a road to travel with the purpose of re-educating one's heart in love, "removing the heart of stone and introducing a heart of flesh" (Ezk 36:26)—that is, an inner disposition of sincere love.

To re-educate one's heart in love towards the sick is simply to humanize oneself, to become humane, sensitive, and open to each to bring humanity to care of the sick and the whole setting.

The sick, as human persons, cannot live without love. They need to find a loving attitude in us, understanding and generous service. They desire and hope to be received and assisted with human warmth; they feel the need for a human relationship, in addition to technical attention and service.

For us Christians there is an additional commitment. Into the natural tendency, a result of the sentiment leading us to love our neighbor, there is introduced an inner reality or force which is part of the supernatural order—the gift of charity, a fruit of the Holy Spirit—that is, the God who is Love.

This love called charity is introduced into human nature and joined to natural tendencies and aspirations; it pervades the being and resources of the heart; it turns into a source and energy for fraternal, deep love, in the capacity for self-donation.

This gift of the Holy Spirit demands docility to God's action. The love resulting from such docility is spontaneous and tender, serene and powerful in stimulating, developing, and regulating all the resources and impulses present in the human heart.

In addition, charitable love endows basic human qualities with virility, strength, and support and keeps us ever open, active, and dynamic in relations with others while orienting, inspiring, and informing concrete acts and gestures.

It does not give rise to personal selfishness. It stimulates and regulates instinctive motivations, placing the sick at the core of action, truly desiring the welfare of patients, conveying human and spiritual wealth, introducing itself into the state of patients, and making itself available for their good and integral recovery or to help them to die with dignity.

We may say that charitable love leads us to act with joy and enthusiasm because it fills all care with warmth and humanity, making it effective while elevating and perfecting it.

Service will be as love is. Pope Paul VI said, "Your worth is in keeping with your hearts." In the world of the sick, in their whole setting, those suffering need to see, smell, hear, and touch this divine dimension in us, which, in more familiar terms, is known as "humanity." We ourselves no longer want so many words—we want witness, consistency, life-fostering attitudes.

Another aspect of this divine dimension is when, after contemplating the attitudes and life of Jesus, the suffering, in their dismay, discover and bring out a capacity, a strength, or an en-

ergy that has often been unknown previously which makes them mature as persons. And many of us who are in this environment of pain frequently see these people—men and women, children and the young, adults and the elderly—whom suffering has expanded and developed, for they draw from their limitations the courage, perseverance, and fortitude to go on struggling for life in fullness or for the fullness of life within limitation. It, so to speak, like the blackish, rough, jagged stone of the diamond, in which, as it is struck and cut, the darkness disappears and gives rise to clarity, brightness, transparency, and elegance.

St. Camillus of Lellis, the protector of those serving the sick, asks us not to put out that divine spark in the midst of the world of pain—that is our commitment, our responsibility. We must be Christ's hands and heart. We must make his mercy and compassion present and visible today.

This cannot leave us indifferent. In looking at Christ, we see that Jesus becomes solidary with those suffering, discovers the needs and desires of the sick, becomes incarnate in their situation and their traveling companion, like a brother, to give them hope and health—or help them towards a good death.

In this generous service a Beatitude is already present on earth: "gladness of heart and spirit arising from the comfort sought for the sick."

To carry out such a great and noble mission—to consecrate our lives to Love for science and the search for human happiness—we must not remain on a theoretical level regarding our being and acting, for our statements will be nothing but works of literature if we fail to "embody" them in our lives.

I wish to conclude with a Chinese proverb which says, "When the mind is not obstructed, the result is wisdom; and when the spirit is not obstructed, the result is Love."

Anthony de Melo, an Indian Jesuit, holds this conception of Love: "Only if you love will you be happy, and you will love only if you are happy. And to love is a state which does not choose who to love, but loves because it cannot do anything else, because it is *love*.

The response of love is always what the other needs, for true love is clear-sighted and understanding; it is always on the side of the other.

God is truth, happiness, and reality, and He is the source always ready to fill us with love to the extent that we open ourselves freely to Him.

He will give us the Peace, Strength, and Love we need to embody today's nursing and medicine with a deep commitment to justice and charity surging from the very heart of the God of Mercy so as to make it evident to all needing us in the health field.

It remains for me only to ask Him and Our Lady of Guadalupe, Mother of Mercy, to bless all of us who work in health care so that, fortified in prayer, with a sense of solidarity and cooperation in the facilities where we are active, we may render mercy a living reality and at the end of our days be received in the other life with these words: "Come, my Father's blessed ones, for I was sick, and you visited Me.... For what you did to the least of my brothers you did to Me."

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The Chaplain, Religious Assistance, and the Chaplaincy

1. Introduction

At the entrance to St. James' Hospital in Rome the following sentence is engraved: *Come to be healed, and, if not healed, at least cared for, and if not cared for, at least consoled*.

The three verbs included—"heal," "care for," and "comfort"—propose distinct horizons of health and hope. Health workers, patients, and relatives often focus their attention on one of them, generally physical healing, neglecting and minimizing the value of the others.

On examining the priorities of the different professions, we might say that doctors are mainly concerned with "healing," nurses with providing "care," and chaplains with "consoling." Doctors, in view of their technical and scientific training, feel they have been designated primarily for the task of healing—by way of precise diagnoses, surgery, or therapy aiming to restore health and life to the sick.

Nurses' concern is to care for and alleviate suffering in response to patients' physical, mental, and psychological needs.

The contribution of chaplains and volunteers is to "comfort" or console those experiencing pain by way of gestures conveying proximity and solidarity and to accompany in the process of dying those who cannot be helped any further by human science.

Though representatives of different disciplines may give priority attention to one of the aforementioned verbs, it is important to conceive of them as interconnected and mutually integrated; as a result, healers at the same time provide care and consolation and those offering true consolation at once contribute to healing and attending to wounds.

Starting from this assumption, I propose to set forth the constructive contribution which pastoral care can make to the "healing," "care," and "consolation" of the person.

When I speak of pastoral action, I am referring, first of all, to chaplains, but also to the chaplaincy as a project of the Church and to pastoral co-workers as resources and instruments for spreading the *Gospel of mercy*. The models according to which pastoral presence is structured and conveyed are linked to various cultural traditions and the pastoral vision of those working in this field.

2. The Identity of the Chaplain

As regards the chaplain's identity, the requirements for performing this function vary from country to country. In some nations only those who are priests or ordained ministers are recognized as such; in others women religious or lay people with appropriate training and the approval of their bishops or local churches are included.

We have prepared a map illustrating the approximate distribution of chaplains in Europe in terms of whether or not they are ordained and whether their work is full-time or part-time. Readers should bear in mind that these chaplains belong to different religious traditions: the Scandinavian countries (Norway, Sweden, Finland, Denmark, and Iceland) are mostly Evangelical Lutherans (80-95%); central European countries (Germany, Holland, Switzer-

land, and Hungary) embrace a variety of traditions; the Latin countries are mainly Catholic; and other nations are characterized by the predominance of one faith: the Greek Orthodox in Greece, Catholics in Ireland and Poland, and the Anglicans in Great Britain.

Summary Table	Full-Time Work		Part-Time Work
AUSTRIA	Chaplains	90	105
	Sisters	10	15
	Laity	30	10
DENMARK	Chaplains	3	37
FINLAND	Chaplains	16	10
FRANCE	Chaplains	800	200
	Sisters	400	3.000
	Laity		
GERMANY	Chaplains	1.300	700
	Deacons	45	
	Sisters	110	
	Laity	400	
GREAT BRITAIN	Chaplains	248	1.200
	Sisters/Deaconesses	41	
	Laity	14	
IRELAND	Chaplains	80	35
	suore	70	
	Laity	3	
ICELAND	Chaplains	10	
ITALY	Chaplains	1.000	100
	Sisters	25	300
NORWAY	Chaplains	84	25
HOLLAND	Chaplains	700	300
POLAND	Chaplains	40	250
PORTUGAL	Chaplains	50	230
	Deacons	1	
SPAIN	Chaplains	850	300
	Sisters/Laity	300	
SWEDEN	Chaplains	183	
	Deaconesses/Laity (full- or part-time)	147	
SWITZERLAND	Chaplains	80	40
	Sisters/Laity	15	
HUNGARY	Chaplains	8	
	Sisters/Deaconesses	35	

Aside from possessing the official requirements, the chaplain should have the qualities discussed below.

2.1. Motivation for Service

Motivation is the stimulus of life. It is impossible to accompany the sick properly if one lacks the necessary inner motivations. The tendency of bishops and major superiors to assign chaplains to a hospital solely on the basis of circumstantial needs or because priests were no longer capable of providing active service in parishes has often had a negative effect on attention to the sick and to the hospital community.

The pastoral care of the sick requires a sensitive, well-prepared heart, not improvisation or forced situations.

2.2. Specific Training

The hospital is at present one of the most sophisticated scientific environments and, from a pastoral standpoint as well, requires competent, professional people not guided only by good will. In recent years centers for the pastoral theology of health care or practical courses such as Clinical Pastoral Training have arisen to provide chaplains with human, theological, ethical, and pastoral preparation enabling them to make a more effective and creative contribution to the sick and health workers.

Pastoral Contexts

The environments where pastoral action takes place include a variety of contexts, from general hospitals to nursing homes, from psychiatric institutions to rehabilitation facilities, and from university hospitals to hospices.

The *horizons* for pastoral activity include the sick, families, health personnel, and parishes, among others. Focusing our attention on the chaplain, we shall seek to accompany him on a sort of virtual journey from which there emerge the different roles he may perform in the course of his pastoral work.

3. The Chaplain's Roles

In the diverse encounters the chaplain experiences every day we may delineate a mosaic of roles, each with its own space or time in relation to the sick. We shall review these roles and specify the significant elements distinguishing them.

3.1. The Symbolic Role

The chaplain is not there to announce himself, but Someone or something greater than himself. He does not regard himself as the salvation of the sick, but as an instrument in the hands of the One who saves; he has no pretense of representing love, but is a humble reflection of the One who is Love.

For the sick as well, the presence of the chaplain calls forth a vaster reality, linked to God, the Church, the values of Christianity, membership in a parish, the meaning of prayer and the sacraments, the spiritual dimension, and hope of paradise and a new life.

On some occasions, the chaplain's visit itself may unleash negative reactions connected with wounds which have not healed, experiences which have produced resentment and alienation, and memories marked by disappointment and bitterness. In these cases the religious presence is associated with unhappy connotations, such as authoritarianism, control, condemnation, guilt, inconsistency, harping on sin, a lack of humanity, and the fear of hell.

The positive or negative perception of the chaplain largely depends on the patient's prior experiences with

religious figures; the possible rejection of his visit must not be seen as a rebuff of the person himself, but of what he symbolizes. The chaplain's ability to handle this critical moment with sensitivity and good grace may foster a climate conducive to healing a long-standing wound.

3.2. The Role of the Consoler

The chaplain, imitating the Good Samaritan, is there to pour "the oil of consolation" and "the wine of hope" on the wounds of the wounds of the unfortunate.

The first form of consolation is to "listen" to someone by accepting that person's reactions and concerns, thoughts and feelings. Those suffering need to express their pain without feeling themselves to be judged, blamed, or trivialized by what they are undergoing. They need understanding, not ready advice, respect, not pity.

Comfort is conveyed by the style of *pastoral presence* as well: there is a presence which wearies people and another which gives them new life, a visit which causes irritation and another which prompts a desire for new encounters, a meeting which creates indifference and another which leaves a pleasant memory. One presence may speak of humanity and warmth; another, of formality. Sometimes a short visit becomes an occasion for confrontation, whereas another may signify convergence. A great deal depends on the pastoral worker's human attitudes.

The Gospel of consolation is also conveyed through *faithfulness in accompanying*, especially in those circumstances where illness is prolonged over time, when burdensome and taxing treatments are needed or when the time approaches to conclude one's earthly pilgrimage. The true consoler is not the one who in the darkness of Good Friday hastens to proclaim the Resurrection, but the one who is willing to keep watch on Good Friday and thus become a symbol of hope.

3.1. The Role of the Intermediary

The chaplain does not give priority attention to illness and medical care, but to inner experience and interpersonal relationships. His helping relation aims to untie the knots interfering with the interior health of his interlocutors and to promote healthful relations. He works to foster relations on the following levels.

3.3.1. Patients' Relation to Their Inner World

It has been said that today, in the Western world, the only way to reflect and meditate is to become ill. Once individuals are hospitalized, they are no longer immersed in myriad stimuli and external distractions, but are forced to look within, revisit their past and their way of life, and question themselves on the reasons for pain, sometimes having to make tough ethical choices.

On the basis of this experience of introspection and verification, they may mature and gain a different perspective on the world; what previously seemed important now appears to be secondary and irrelevant, and what was taken for granted is now appreciated and valued. The chaplain introduces himself into this time of crisis and reflection and, by his mediation, seeks to contribute to transforming the crisis imposed by illness into an opportunity for human and spiritual growth.

3.3.2. Patients' Relations with Relatives

In many circumstances the sick face their condition with realism and balance whereas their loved ones let themselves get carried away by anxiety and an excessive need to take charge paternalistically in their regard; they provoke conflict with care providers or cast blame on one another. The family plays a vital role in the experience of those suffering, but its contribution must be manifested in affection, not in excessive anxiety or self-pity, in respect for roles, not in control over decisions, in serene, open communication, not in the systematic denial of truth, and in the affirmation of the individual, not in constant negative criticism.

The chaplain seeks to know the relatives, not just the patient, to assure them of his availability and presence, give them useful information, facilitate communication with care providers, gain valuable insights into the personality and resources of the family's hospitalized loved one, and accompany them in the painful moments of death and mourning. He particularly works to dissolve dynamics which interfere with the patients' communication with the family context, explores constructive strategies to face the challenge of an unfavorable diagnosis or of a chronic illness together, and identifies and sustains family members capable of helping the others to deal with painful events.

3.3.3. Patients' Relations with Health Professionals

Suffering always involves adapting to new roles, like

that of the patient, to new environments, like the hospital, and to new languages, like the one used by health professionals. Whoever crosses the threshold of a health facility often feels bewildered and confused in the new setting and needs to regain serenity in a trusting relationship with those trying to improve the individual's condition.

It is important for doctors, nurses, and other professionals providing care to relate to patients as people, not as numbers or dysfunctional organs or interesting clinical cases to be submitted to an upcoming symposium.

Conflicts and tensions often arise because patients or relatives perceive that care providers adopt depersonalizing, authoritarian, or dehumanizing attitudes towards them, relegating them to a passive role as observers of the process, not sharing in responsibility and decisions.

The chaplain can occupy a vital place in mediation by seeking to sensitize personnel to the need to recover the centrality of the patient in service and avoid the constant risk that the hospital will become a workplace for the healthy rather than a place where the sick receive care.

3.3.4. Relations Among Patients

A few years ago, in California, research was conducted on the seriously ill in which they were asked what person they felt freest to confide their inner states to at the most critical points in their illness. From the data gathered the following emerged: on an ascending scale, the last people patients would confide in proved to be doctors and technicians because they were seen as too occupied to listen to their feelings and concerns; nurses received a ranking which was not much better; the chaplain's position was variable: for some he was an ideal figure to open oneself to, but for others he was entirely secondary.

Relatives were ranked fifth, more or less, since many patients did not feel free to burden their love ones with their distress because they were already weighed down with so many adaptations imposed by illness. A significant place was reserved for friends because they appeared sensitive and objective enough to ensure listening capacity and solidarity and were not entangled in family dynamics.

The most interesting insights involved the two groups ranked first and second. The top ranking was reserved by many for volunteers, whose unselfish visits were not conditioned by roles or other interests, but were prompted by human and religious motivations. Most people gave top ranking to other patients as credible persons who could understand pain because they themselves were experiencing it in different ways personally.

Pain creates alliance and union, and love issues forth in its shadow. The survey results open up a vital area for pastoral care and point to a creative role for the chaplain linked not only to his capacity for dialogue with individuals, but to creating community and fostering exchanges and mutual aid among those making the same pilgrimage.

Informal sharing in a hospital room or ward and the formation of groups for mutual assistance among persons undergoing a specific experience of illness or mourning may constitute placing their experience and wisdom at the service of others and of hope.

3.4. The Role of "Animation"

"Animation" means to provide a soul, to bring out people's vitality. It is important to discover modes and strategies for stimulating health workers to express their potential; otherwise work becomes routine, structures become fossilized, and professionals lose their motivation and creativity.

The chaplain can carry out valuable action in animation at different levels: first of all, he seeks to affirm people by helping them to recognize their gifts and values so as to place them at the service of personal growth or of the institution. A second form of animation consists of being able to identify, motivate, and cultivate professionals willing to engage in projects for shared witness.

Cooperation in training volunteers may become one of the major ways to make serving the sick more humane. The true leader is not the one who promotes himself or his own leadership, but the one able to make the most of the talents of others and foster them for the good of the community.

To provide pastoral care today is increasingly the result of cooperation and less and less a matter of individual leadership. There are two models being applied in Italy to animate pastoral action.

3.4.1. The ***chaplaincy*** is made up of a limited group of persons—priests, religious, and laity—engaged in pastoral care on a full- or part-time basis. In practice, the chaplaincy is formed by one or more chaplains, one or more sisters, and one or more lay people who have acquired special training. Through shared programming and meetings for verification they

seek to bear witness together to the Church's presence in the health field so as to contribute to the humanization and evangelization of health workers and facilities.

3.4.2. The ***pastoral council*** is an organism made up of health workers, administrators, volunteers, and patients with a Christian commitment to bear witness to Gospel values in health care. It may vary in number from 15 to 30 people representing the different groups active at the hospital. The pastoral council is, above all, a tool for bringing forces together and creating a community bond among those who feel a commitment to bear witness to the spirit of the Gospel.

Secondly, this spirit of interdisciplinary cooperation represents one of the most effective ways to make an impact on the broader hospital community through projects and initiatives involving liturgy, training, recreation, and charity which contribute to stimulating the life of an institution.

The chaplain's capacity to promote these initiatives is nothing but getting into harmony with Church teachings recalling that pastoral action is not the exclusive patrimony of priests, but the responsibility of the whole Christian community.

3.5. The Catechetical Role

In the course of his earthly life, Jesus used parables and images taken from everyday life to enlighten and instruct his disciples and the masses. Imitating the Founder, the chaplain prizes the opportunities offered by ministry to educate the sick and give meaning to pain, to draw light from the Word of God and from reflection.

To catechize sometimes means to transform a venting of bitterness into a prayer; it is often patients themselves who become evangelizers and teachers of the healthy by their example, their faith, and their serenity. The wisest teachers are the most vulnerable people; the sick, for whoever is able to listen to them, become a university, not so much through the contribution they make to science as through what they give to human wisdom.

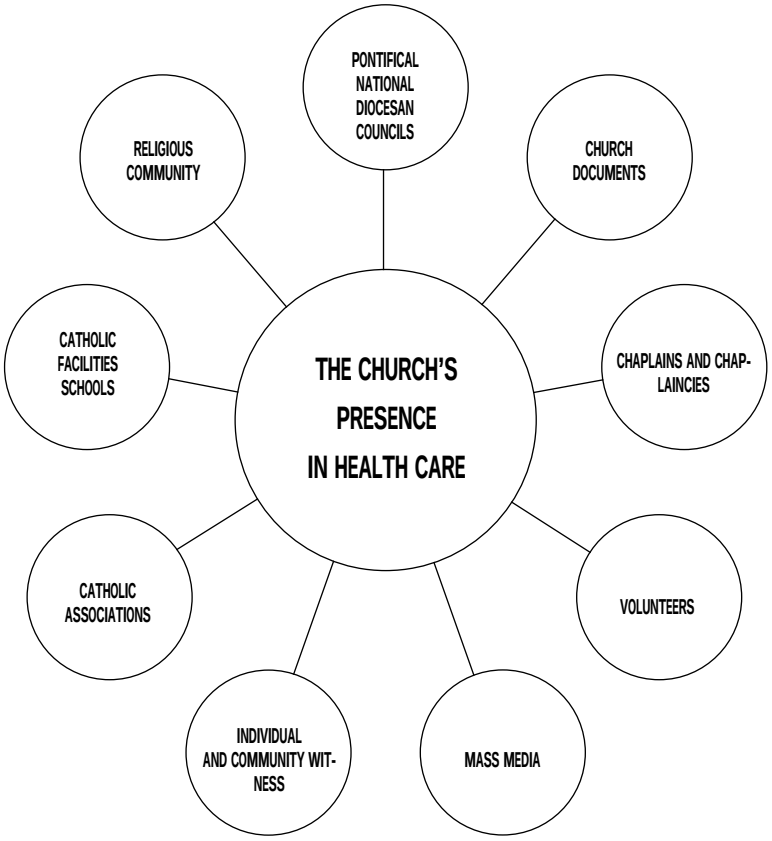
There is a gift behind every suffering face. It depends on the visitor to receive its messages. Those who let themselves be educated by the sick learn to face the challenge of sickness and death, prepare for old age, appreciate their own health more fully, relativize problems, and keep themselves more humble and compassionate.

There is a catechetical contribution which the chaplain makes to health personnel and to the hospital community. Through reflection on the Word of God, moments of prayer or paraliturgies, Masses in the wards, and the administration of the Anointing of the Sick in a community he has the chance to sow seeds in the ground of listeners, bringing their faith to maturity, purifying the images of God prompting fear, educating people in mutual forbearance, and stimulating responsibility.

In the context of interdisciplinary cooperation and ethics committees, the chaplain's presence can serve to bring out the values at stake in the face of complex challenges in health care—from in vitro fertilization, euthanasia, and organ transplants to patients' rights—and foster choices and decisions respecting the principle of human dignity.

3.6. The Role of Linkage

The chaplain is a member of a Church bearing witness to her presence in health care by way of various forms and resources.



The chaplain or chaplaincy represents a tessera in a variegated mosaic of resources. Within a hospital there are organizational responsibilities in ensuring the space and services needed to do this work, maintaining contact with the administration and medical authorities so as to cooperate with the goals of the institution, and informing the bodies concerned about the initiatives and projects of the chap-

laincy and pastoral council.

The hospital is not, however, an island, but part of a larger community, and the current tendency to reduce the length of hospital stays to a minimum involves strengthening support structures in the community, especially the parish.

The chaplain maintains contact with the bishop, those responsible for parishes and diocesan prefectures, and the groups visiting the sick so as to harmonize efforts, provide quality service, and contribute to sensitizing the whole Christian community to the world of suffering and health.

One of the best ways to sensitize is the World Day of the Sick. Instituted by John Paul II, this initiative is gaining ground as the most effective and widely applied tool for focusing the attention of the Church and society on the sick and prompting new energies for this service.

3.7. The Ritual Role

The image of the chaplain is often confined and reduced to this religious dimension—that is, to the role of someone passing by to give a blessing or administer the sacraments. The worst danger is for the chaplain to situate himself on this horizon, limiting his action to the liturgical and sacramental sphere. The ritual dimension has its healing contribution to make, but it constitutes a point of arrival, not departure, for an encounter.

Where possible, it is important to build relationships with the sick on the basis of the elements previously mentioned, such as the role of consolation and mediation, and, in the light of what emerges, discern the religious contribution which best responds to the needs of the interlocutor. On some occasions prayer represents the most appropriate response: it takes on special meaning in the time of suffering and can transmit the strength, peace, and serenity which are not found in medicines, but in a deep relationship of trust in God.

On other occasions the sacraments become a medicine in the soul and means to receive God's grace and religious comfort; in the time of illness the sacraments of the Eucharist, reconciliation, and anointing of the sick are particularly significant, and, depending on the patient's situation, the chaplain must determine the most fitting times and modes for proposing them.

A community aspect to the ritual dimension is linked to the chaplain's style in presiding at and animating Masses so they will not be hasty and lifeless, but become occasions to celebrate faith, nourish hope, and inspire charity.

3.8. The Ecumenical Role

In today's society, increasingly multicultural and multireligious, the presence of a chaplain with an ecumenical spirit is needed.

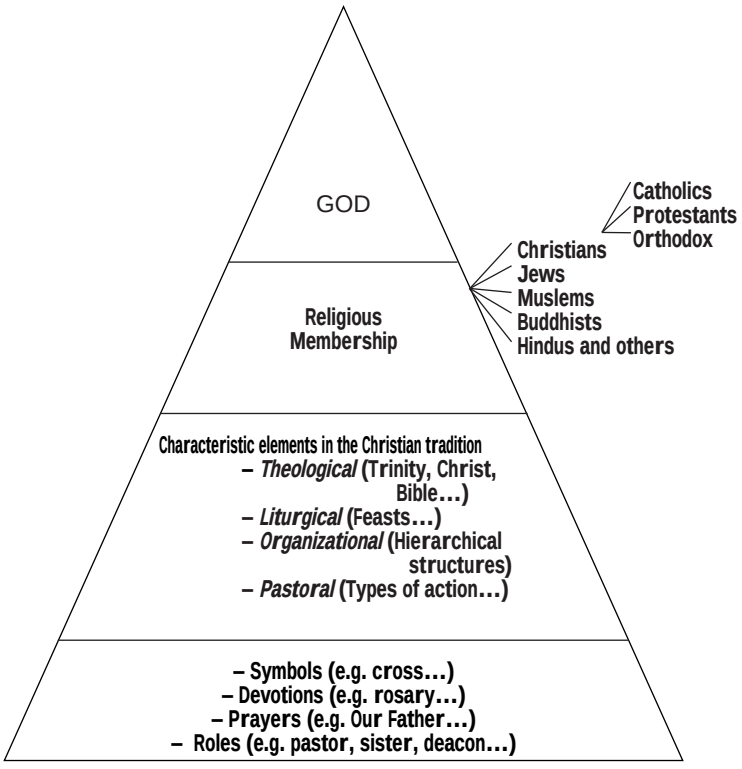
The large cities have turned into a meeting place of the different cultures, and the hospital is a crossroads for humanity. In hospital wards we encounter, side by side, the Ethiopian and the Peruvian, the Pole and the Egyptian, the Indian and the Spaniard; each has a personal story and a cultural and religious patrimony.

The chaplain makes his presence felt in this mosaic of traditions by making the contribution of his humanity and a visage of receptiveness and goodness.

The ecumenical perspective particularly involves a capacity for distinguishing two dimensions of people's patrimony: religious tradition and spirituality.

3.8.1. The ***religious tradition*** is the set of values, practices, rites, and external manifestations which constitute the baggage of a specific faith transmitted through the channel of a community and a culture. For instance, the birth of a nation involves individuals' being exposed to, assimilating, and adopting as their own the religious tradition of the family or of the cultural context they belong to.

We can indicate this frame of reference by using the image of a pyramid whose steps represent the different components of religious tradition.



RELIGIOUS TRADITION

3.8.2. ***Spirituality,*** on the other hand, is not necessarily mediated by culture, but forms part of individual experience and embraces a broader horizon than religious tradition. Spirituality may be directly linked to belonging to a religious tradition, but for many individuals it is not. More than in the past, today there are many persons who do not frequent the Church, the Temple, the Mosque, or the Pagoda, nor do they seem interested in the values proposed by these institutions, but they possess a rich spirituality.

Spirituality is what gives meaning to existence, the values which motivate action, the relationship with God and with the sacred, a sense of one's involvement in the world, and so on.

The chaplain becomes ecumenical to the extent that he is able to receive, in fragmentary dialogue, the spirituality animating people's existence. We shall trace out some elements which may characterize a person's spiritual patrimony.

* A *relationship with God* or with the divine. Conversation with patients reveals their differing images of God, their perception of his action and presence in the world, and their diversified modes of prayer and language to encounter Him.

* The *meaning of suffering*. Every individual takes a different attitude to the experience of vulnerability and pain and appeals to inner resources enabling that person to make suffering fruitful.

* The *meaning of life and death*. The impact of pain prompts deep queries. What is the purpose of life and the meaning of death? What values or faith can help us face the inevitability of death? What do we believe about the afterlife?

* The *need for forgiveness*. On examining their past, people always find deficiencies, weaknesses, inconsistencies, disappointments, and errors of omission and commission. Remorse and regret concerning one's own fragility bring out the need for forgiveness: some need to receive it from God, some from others; and some are called to forgive themselves.

Intimate conversation becomes an occasion for the sick to "confess" their errors and, indirectly, to ask for forgiveness.

The *relationship with others*. "From this they will all know that you are my disciples: if you love one another" (Jn 13:35). The spirituality of individuals is particularly expressed by their way of relating, and a different spirit is thus observed in those relating to others on the basis of solidarity, courtesy, and charity, as opposed to those whose relational motives are selfish and aimed at manipulating and exploiting their neighbor.

The spirituality of persons declaring themselves to be nonbelievers, but whose lives are marked by intense generosity and genuine respect for their neighbor, may even be much deeper and more authentic than that of others who go to church daily, but whose relations are prompted by envy or jealously and constant criticism of others.

* The *relation to oneself*. One text states, "I sought my God and my neighbor, but I found neither; I then sought myself and found all three." Self-awareness and self-acceptance are an essential presupposition for accepting God and others within oneself. Those exiled in their own homes find it hard to find a dwelling place for God and their neighbor therein.

Those with a negative self-image constantly tend to underestimate themselves; they do not value themselves as a gift of God; they condemn themselves by limiting their own freedom and potential and impoverishing their spirituality. St. Irenaeus said, "The glory of God is the fully alive creature."

* The *relation to nature*. If many discover God by becoming familiar with the history of salvation or looking into the eyes of a child, a beautiful woman, or an old man, others detect his presence especially in contact with the beauties created by Him: to appreciate the cycle of the seasons, to admire creation from mountain tops or the depths of abysses, to contemplate a flower which is opening, to enjoy the tranquillity of a lake, to lie back in the shade of an oak tree, and to photograph the beauty of a sunset become spiritual moments revealing the mystery of things, the gratuitousness of life, and the Providence of God.

In encountering the voices and colors of creation, man encounters his Creator, and his contemplation becomes prayer, worship, and thanksgiving.

4. Conclusions

I have sought to trace out a map of pathways, a range of roles which may make the presence and witness of a hospital chaplain and chaplaincy more incisive. But it is useless to have a map if we are unwilling to take a trip.

Awareness is the first step pointing to roads to be traveled, but humility, motivation, and tenacity in commitment to the journey are then needed.

The challenge of communicating the Gospel in a com-

prehensible way in the field of health requires that chaplains and pastoral teams be increasingly motivated to get training, by way of courses and practical exercises, in order to become more competent, be willing to cultivate a spirit of cooperation and programming with other persons and groups engaged in humanizing and evangelizing the hospital, and be creative enough to deal with the challenges posed by the complex world of pain and health care with imagination and originality.

Rev. ARNALDO PANGRAZZI, M.I.

Testimony

Health in Bolivia

Charitable Service
on Behalf of Life
Dominican Sisters

Health in Bolivia

1. Bolivia

1.1. Population and Projections

Bolivia is the only "Mediterranean" country in South America. Its borders extend over 1,098,581 square kilometers. According to projections by the National Statistics Institute based on the census of June 1992, there are 6,344,396 inhabitants. Population density is 5.78 inhabitants per square kilometer, much lower than in other Latin American countries.

If population maintains current growth rates, in the year 2000 there will be eight million inhabitants.

Population is growing faster than the country's economy. Per capita income has decreased, and purchasing power is declining as a result of constant mini-devaluations, according to the Bolivian Stock Market.

At present the country has the highest fertility rate in Latin America, estimated to be 6.2 children per woman, over 50% higher than the average observed in the rest of the continent. In rural areas the fertility rate reaches 8 children per woman.

In 1992 58% of the total population of Bolivia was concentrated in the cities; since 1976 there has been a considerable increase in migration from the countryside to the cities. Since 1985 the phenomenon has intensified, as a result of Decree 21060, which prescribed layoffs, especially among those working at mines, who moved massively to the cities.

1.2. Basic Indicators

* The mortality rate among those under five years (1991): 166 per 1000, according to UNICEF's *State of Children Worldwide 1991*.

* Child mortality varies according to the sources.

- 105 per 1000, according to the aforementioned UNICEF data, as regards 1989.
- 102 per 1000, according to the Ministry of Health.
- 270 per 1000, according to the book *Critical Analysis of Reality* (4th edition, 1989).
- 213 per 1000, according to a 1987 CERES study.
- 110 per 1000, according to the *AIS Bulletin* in 1992.

* GNP was $570 per capita in 1988.

* Life expectancy at birth was 54 in 1989.

* Population under the absolute poverty level was 85% in rural areas in the 1980-1988 period.

1.3. Health

Health levels reflect living conditions. In spite of basic changes taking place in the decade from 1980 to 1990 in the country's health policies, they have not kept pace, unfortunately, with global policies tending towards an improvement in living standards. In addition, the application of dehumanized economic systems has yielded excellent results in terms of economic parameters, but its social consequences are clearly seen in the indigence in which different groups live and in the high mortality rates deriving from disease and malnutrition.

The economic crisis the country is going through alarmingly intensifies health problems, especially among children and women. The structural transformation requested by international economic macro-organizations has had a negative impact on government health expenditures in most of the developing countries, and concretely in Bolivia.

According to studies conducted by our organization, 80% of the population lives in conditions of extreme poverty. UNICEF also maintains that 80% of the population is unable to meet its basic needs, and in recent years workers' real salaries have dropped by 44%.

Though the programs run by the National Health Secretariat, particularly the one for grassroots mobilizations for vaccinations, have been well received, with an excellent outreach, these measures have nevertheless proved insufficient, since they have not been accompanied by policies aiming to improve living conditions.

Adequate nourishment would be the ideal complement to improve heath indices and living conditions in the country. It should be stressed that improved living conditions do not come about through decreasing population, but rather by way of production which creates jobs and salaries allowing people to live in a worthy fashion.

According to studies by the IME, about 80% of the Bolivian population presents a health situation with a high level of risk because of a lack of social security, low life expectancy, and minimal access to health services.

The country's rugged geographical conditions, the dispersion of the population in rural areas, and cultural and social barriers are factors conditioning services for prevention and care.

If we add the high cost of medicines to these considerations, we can say that the health situation in Bolivia is one of the most critical in the world.

Infant Mortality

The infant mortality rate, according to the Ministry of Health, is 102 per 1000, as mentioned above.

The ten main causes of death in children under ten are the following.

DISEASES	NUMBER OF CHILDREN	%
1. Perinatal diseases and those in early infancy	2.377	44,2
2. Respiratory diseases	1.140	21,2
3. Gastrointestinal	478	8,9
4. Whooping cough	404	7,5
5. Insufficiently defined	364	6,8
6. All infections and parasitic diseases	180	3,4
7. Scarlet fever	99	1,8
8. Illnesses associated with allergies, malnutrition and anemia	79	1,5
9. Measles	71	1,4
10. Tetanus	49	0,9

Consequently, 60.6% reflects transmissible diseases, 33% of which are preventable through vaccination and 27.6% by action on the environment.

Those under five years of age represent 65% of all child mortality.

60% of the ten main causes of death involve transmissible diseases, 33% of which can be controlled by vaccination, and 27% by environmental improvements.

Mortality in children under five represents 65% of mortality in general. The mortality rate in this group enables us to measure directly the health of mothers and children and to grasp other factors, such as income and the availability of food, access to potable water, and effective improvement of the environment.

60% of the ten main causes of mortality involves infectious diseases, 33% of which may be controlled by vaccination and 27% through action to upgrade the environment.

In Bolivia 60,792 children do not reach the age of one. 166 children die each day—a rate of 7 per minute. Perinatal mortality is 110 per 1000.

In some places child mortality exceeds 200 per 1000.

According to the former Minister of Social Security and Public health, now the Health Secretary, child mortality is 102 per 1000.

Acute respiratory infections kill about 20,000 children under age one each year.

High-Risk Diseases

* Measles and whooping cough are major diseases in the context of child mortality.

* The incidence of tuberculosis is 3 per 1000 annually and is tending to increase on account of poor socioeconomic and health conditions.

* Goiter is a major public health problem because of its serious consequences, especially for mothers and children.

2. The Church and Health

The Church is responding to the problems described above by supplementing government action in its proper functions and starting up basic healthcare programs—that is, by promoting health and preventing disease, on the one hand, and by providing second- and third-level care, on the other.

The Church is doing this work throughout the country, with different programs, projects, and health activities (from small health centers to large hospitals maintained thanks to the efforts of the Church itself, of foreign financing, and, to some extent, of compensation by the National Health Secretariat of the Ministry for Human Development.

3. The Church and the New Laws

On June 30, 1995 the Law for Citizen Participation was promulgated, the same law which is prompting discussion and sometimes expectation in different areas of civil society. On January 1, 1996 the Decentralization Law also went into effect.

The transformations foreseen by the application of these two laws in every sphere of the country's economic, political, and social life warrant analysis enabling us to gain better understanding of the nature, possibilities, scope, and limits of these laws affecting all Bolivians.

Though we are familiar with health problems at present, since the two new laws went into effect there has been arising a new problematic requiring immediate responses and solutions, uniform and unitary implementation in relation to the government and other bodies responsible for applying the new laws.

It is thus indispensable to analyze and give priority to the problems which will arise from implementation of the new laws in health programs, thus seeking adequate coordination and consultation and unifying the criteria for action plans to improve health and living conditions among the neediest in the population.

In accordance with the Law for Citizen Participation, responsibility for health services has been transferred, as regards infrastructures, equipment, and costs, to municipal governments.

According to relevant regulations, infrastructures and equipment are to remain in the hands of the Church and NGOs if they so desire. This subject deserves careful analysis within health programs, in the light of participation by municipal government in the development of the different programs and projects and in their execution.

It is hoped that these new parties in the health field will be increasingly involved in the work and development of the various health facilities, projects, and programs.

Finally, as a result of the implementation of the Law for Citizen Participation and the Decentralization Law, which represent legal support for the free-market model, the new health model will be applied in response to the aforementioned changes.

The new health model is in the process of being put into effect, with the following administrative levels.

a) The Health Programming Unit, at all the institutions providing primary care. At this level of administration the Lo-

cal Citizens' Health Committee is to be organized, with participation by delegates from Basic Local Organizations for participatory planning of health programs and activities in the territory under the jurisdiction of a healthcare institution.

b) In relation to the population and the territory, the Basic Management Unit corresponds to primary care and some secondary care (like the "Health Hospitals") capable of meeting patients' needs in basic health specialties under the jurisdiction of a municipal section. At this level the Territorial Health Administration is to be organized, with participation by the city, the health sector, the BLO, and representatives of other institutions working in this field (the Church and the NGOs), within this jurisdiction. Its basic function is to work out the Annual Program for Health Action, allocate resources, and administer the program.

c) The Territorial Health Authority is a union of municipal jurisdictions. In general, it may correspond to an association of municipal sections located in more than one province, as is the case with DITES in Valle Alto of Cochabamba, which corresponds to the Second District of that department.

On this level of health care, the Subregional Health Authority is to be organized, whose main function is to work out, manage, and administer the Subregional Health Program, in addition to coordinating the efforts and resources of the different municipal governments, of representatives of the health sector, of the BLOs, and other groups connected with care so as to attain common goals.

Finally, as a result of the implementation of the Law for Citizen Participation, health services have been transferred, as regards infrastructures, equipment, and costs, to the responsibility of municipal governments.

4. General Agreement Between Church and State

In 1984 a general agreement was signed for the purpose of regulating Church-State relations in health care.

An agreement will now be signed between the State, represented by the Ministry for Human Development, and the Catholic Church, represented by the Bolivian Bishops' Conference, which includes the three major areas in which the Church is at work: education, health, and the family and institutions for children and adolescents.

5. Prospects

At present the Bolivian Bishops' Conference is seeking to implement a Three-Year Plan to focus the organization of the healthcare ministry in the following areas.

* To establish strategic guidelines and coordination for all the Catholic Church's health activity in the country.

* To take positions on health problems and have an impact nationally on the Catholic services which are complementary to government action.

* To draft a *Charter for Pastoral Care in Health* which will constitute a basic frame of reference for the Church's health work in Bolivia and define the strategies so that the Church's efforts will provide consistent, planned service.

* To help the population to become more aware and give it the ability to solve its urgent health problems by promoting organic and solidary action consistent with the Christian's role in contributing to a decrease in high mortality rates provoked by disease and in the high rate of malnutrition.

* To reinforce and organize Diocesan Health Committees enabling the Church's health apostolate in Bolivia to be structured.

* To promote organic, solidary action for promoting health by establishing a plan for training and communication centering on basic health care and the Church's social doctrine.

* To prepare material for education and training in basic health care and the Church's social doctrine.

Pastoral Project for Health Care in Latin America and the Caribbean

Introduction

The first Dominican Sister of Charity of the Presentation was born in 1696 in France. In 1995 we are celebrating the three-hundredth anniversary of this event. With a view towards the future, Marie Poussepin founded a community of the Third Order of St. Dominic for parish service, education of children, and care of the sick. At present 3200 Sisters work in 33 countries, responding to the most urgent needs of the Church and the world at this time.

The Forty-Eighth General Chapter in August 1984 reaffirmed the priority of this charism in health care. From then on our Sisters in Latin America, committed to serving life, initiated a broad process of discernment and in-depth examination preparing them to draw up a first Pastoral Project for Health Care as a means of stimulus and joint organization which was published in 1987.

In the face of the present circumstances of change and questioning, the need has been seen to deepen and develop the process begun by the Congregation. The Word of God read in church, analysis of situations, and evaluation of action foster precision in clear criteria which, when taken up by a group, open the way for commitment and make it possible to apply priorities and strategies.

Accordingly, after passing through the melting pot of experience on the basis of the initial project, the final one contained herein was worked out.

At the dawn of the fourth century of the Congregation, this Project for Health in Latin America and the Caribbean is reaching every Dominican Sister of Charity of the Presentation with the newness of the Kingdom which "makes all things new," a novelty bursting into the heart of each person when the person opens out to mercy and interior liberation and renders every man a brother.

The bold, valiant presence of Marie Poussepin, imbued with the grace of her beatification, has situated us before the reality of our continent and hurled us into the search for responses which, in keeping with the charism of the Congregation, will make the Gospel present in the world of health.

The commitment to life moving from Sainville and nourished by three centuries of service to charity has led the Provinces and Vice Provinces of Latin America and the Caribbean to update the pastoral project for health, which, having been applied for eight years, presents itself with new vitality in each of its aspects.

– *The reality of change which poses questions* concretely expresses the circumstantial character of this time in history, when strategies and social and economic policies are having an effect on the attainment of conditions favoring the protection and development of life and the preservation of health among our people. In the face of this situation, the Church—and, within her, the Congregation—offer their own reality, with its lights and shadows, in carrying out their pastoral action.

– *Biblical and theological grounding in keeping with our charism* enables us to approach the principles supporting our charitable service in health care. In these pages we may detect the way the same Spirit who animated the action of Jesus, the *Good Samaritan* of history, and spurred the response of Marie Poussepin three centuries ago continues to inspire each Sister's commitment to the "man who fell into the hands of brigands." The Church, aware of her prophetic mission, commits us as a Congregation to announce the Kingdom to the sick and excluded and to defend and promote life through a "new apostolic impetus," an expression of passion for the Kingdom and passion for our own vocation.

The project proper is conveyed in the *mission statement*, the presentation of *challenges, priorities, and strategies*, and proposals for *application and evaluation*.

– The *mission* defines the philosophy whereby charitable service is taken up in the health field at the same time as it expresses the values distinguishing us, manifesting how, where, and with whom we carry out our task of evangelization in favor of life.

– The *challenges, priorities, and strategies* convey the dynamic of our apostolic service in the face of the pressing questions presented to us. This part of the project enables each body of the Congregation in Latin America and the Caribbean to offer its own responses with the boldness and creativity which distinguished *Marie Poussepin*, and also to share the wealth of its missionary experiences through evaluation on a provincial and interprovincial level.

It is our wish that this project, approved by the Seventh Interprovincial Health Assembly, may be received in the most enthusiastic manner and,

for each Sister and each community, be a tool through which the action of the Spirit—who "renews all things"—may pass, launching the Congregation with new impetus *towards its fourth century and the third millennium of Christianity*.

A) Justification

Committed to the Church's and the Congregation's mission to foster health and human life, as the People of God we "feel the duty to announce the Gospel of Life, to celebrate it in the liturgy and throughout our existence, and to serve it,"[1] in keeping with the Congregation's charism.

In this perspective, the Provinces and Vice Provinces of Latin America and the Caribbean have been involved in a joint search since the 1980s, giving rise to the *Pastoral Project for Health in Latin America* in 1987.

Our mission is challenged by new situations today.

– Changing conditions in the world, technological advances, and scientific discoveries, with the resulting ethical-moral implications and socioeconomic and political variations, make new responses to serving health and life urgent.
– The Church, committed to the Project of Jesus, who came so that "they would have life and have it in abundance,"[2] feels herself to be sent particularly to the poor, the weak, and the sick. She discovers her evangelizing mission and manifests her solidarity in affirming life, as a sign of God's saving and liberating action in history.
– The Congregation, animated by the power of its charism, with new apostolic impetus, through inculturation and solidarity, in the dynamic of the Incarnation, sees in pastoral care in health a special path for carrying out the missionary project of Marie Poussepin, provided it is able to decipher this point in history with lucidity and boldness and provide the response required by man today with creative fidelity.

Current reality shows the need for updating our pastoral project in health for Latin America and the Caribbean. The road traveled in the Provinces and Vice Provinces in recent years has been enriching, has made it possible to feel the commitment to life more forcefully, and has unified criteria and principles, helping us to grow as persons and as a community.

B) A Changing Reality Which Poses Questions

1. Latin America and the Caribbean, young peoples, rich in historical experience, offer marked contrasts between wealth and poverty. They feel the threat which dependence brings with it, the scourge of political and economic interests, not just of the rich countries, but also of their governments, which often fight for development while sacrificing their brothers and sisters.

Health Situation

2. Population make-up is undergoing a transition, with a drop in the number of those under 15 and an increase in life expectancy at birth (69 for the 1990-1995 period).[3] Living conditions have improved in some regions, with a decrease in morbimortality.

3. In each country the appearance is perceived of new forms of organization of the people, with an opportunity for major contributions to social transformation (community health promoters proceeding from locally-based organizations, workers' organizations concerned about obtaining improved health services, public and private agencies providing economic and organizational support to develop programs for improving the quality of life in education and health care, especially in outlying areas).

4. A push for professional-

ization and specialization among health care workers, an increase in biomedical, bioethical, and social research, and training in management and technical skills are strong points spurring more efficient and timely health services.

There are some particularly disturbing situations.

5. There is a decrease in general population growth as a result of a reduction in fertility rates, general changes in the structure of mortality, migratory movements from one country to another, forced population shifts prompted by violence, and a search for better living conditions.

6. The epidemiological profile of our countries presents a mixed picture, with the traditional problems of infectious, transmissible, and malnutrition-based diseases affecting mainly children and the extremely poor, alongside the diseases specific to development—cardiovascular and degenerative diseases and cancer.

7. Institutionalized violence, mainly among young people and adults, homicides, traumas, accidents, kidnappings, cases of disappearances, subversion, and armed confrontation reflect a lack of ethical and civic values directly affecting the population's health, with the predominance of culture of intolerance, conflict, and a lack of respect for others.

8. Since the lifestyle is a product of a pre-modern, modern, and post-modern culture (all three levels are simultaneously present in society), it is hard to organize health services, and there result conditions which are conducive to a new set of diseases prompted by the lack of a social fabric and mistaken conceptions of freedom, love, and sexuality.

9. The disintegration of the family, free unions, unmarried and premature motherhood, maternal mortality, abortion, government interference in family planning, and the subjection of women in certain cultures, along with their numerous household and job responsibilities and discrimination against them, are acts of aggression directed against the family in our Latin American societies.

10. Hunger, inadequate food intake, unemployment, ignorance, illiteracy, drug abuse and alcoholism, and unequal distribution of economic, human, and institutional resources are having a growing impact on the appearance of disease and on poor health-care coverage.

11. Man's misguided relation to nature has created phenomena with serious consequences for health such as air and soil pollution, inadequate protection against natural disasters, the extinction of flora and fauna, the elimination of open spaces and natural regions, an increase in urban pollution, and improper waste disposal. Minimal crop diversification and the cultivation and processing of cocaine, marihuana, and amapola are also disturbing.

12. People possess deeply-rooted values and beliefs, sometimes with a magical sense of faith. Both false religious beliefs and superstition or fanaticism may become obstacles to defending and promoting life and health.

Healthcare Systems

13. Health systems are basically directed towards illness, instead of health, as a result of living conditions.

At present Latin American and Caribbean countries have adopted a neoliberal policy restricting government intervention and subjecting society to the laws of the market. This policy presents itself as democratic, but gives preference to the supposed prerogatives of a small minority, overlooks and violates the rights of the majority, casts the burden of health care upon private enterprise, and incorporates new technologies

which are beyond the reach of most people.[4]

14. We are getting farther and farther away from the social justice inherent in the notion of "Health for All." In general, communities lack health services guaranteeing efficient care and giving priority and access to those with a greater concentration of disease-causing factors, beyond all geographical, economic, cultural, and administrative barriers.

15. Reduced government health budgets and inadequate distribution and administration of resources have a negative impact on health coverage and quality.

The population, especially in rural and outlying areas, passively accepts its situation and awaits a solution from government bodies, without working towards change.

16. Governments are tending towards new systems of integral social security so as to guarantee the inalienable rights of the person and the community and obtain a quality of life in keeping with human dignity, determined by principles of equity, efficiency, universality, and community participation.

Advances in health sciences, biomedical research, technology, and improved skills have a positive impact on health, but technology does not always place stress on the patient-health worker relationship.

17. Institutional infrastructures and precarious working conditions have led to a need for unionization among health professionals; it is also apparent that some unions are manipulated by political, ideological, and personal interests with a direct effect on the quality of service and professional performance.

Pastoral Care in Health

18. The Church's charitable action arose with an eminently service-oriented focus wherein religious saw a context favorable to manifesting their charisms. The hospital was viewed as sacred, and the sick were the center of attention. In the course of time, many religious left hospital facilities for different reasons: governments accepted their responsibility to provide health care,[5] trained lay people increased in number, and care became more technical. The process of secularization and secularism in society have also had a notable impact on this process.

19. At present the Church in Latin America and the Caribbean has clear guidelines and options regarding evangelization enabling her to draw closer to specific groups working to defend life. Recent documents of the Church Magisterium are a prophetic denunciation and orientation for pastoral workers to rediscover their identity with a view towards an evangelizing presence in the complex and troubled world of health.

20. Signs of life and hope include reflection and an integral approach to health, the rise of pastoral groups for health, patients' associations, and community organizations that commit themselves to seeking a better quality of life. There are efforts to promote humanity at facilities and to foster ethical values.

21. In some pastoral workers, however, we find little theological and technical preparation for dealing with, clarifying, and orienting social and health problems so as to seek solutions in accordance with reality, with the ethical and moral values promulgated by the Church. Evangelization is still not getting to the root of situations; there is a lack of relation between the Gospel and man's real life, both personal and social, of orienting and organizing pastoral care at all levels—nation, diocese, parish, and institution—as well as awareness of the health apostolate as a task for all Christians, not just a few committed persons.

27. There are vast regions in the countries of Latin America and the Caribbean—poverty belts, isolated villages, and areas marked by violence—where primary health care and the Church's pastoral action have not arrived and where the presence of personnel with pastoral training and professional qualifications is urgently needed.

The Congregation in the Field of Health

23. Our Congregation has been engaged in health care for a hundred years in the Western Hemisphere, where our French sisters arrived, spurred by the power of our charism. Colombia was the country chosen to start sowing the seed in 1873, and the Hospital of St. John of God in Santafé de Bogotá was the first facility of the Presentation in Latin America, a seed which quickly expanded and multiplied into *multiple forms of action*.

24. With a clear vision of the times, boldness, and generous dedication of their lives, often to the point of heroism, our first Sisters devoted themselves to serving the sick, frequently in precarious technical and economic conditions; and yet, for their apostolic spirit, this was not an obstacle to fulfilling their mission for the sake of health and life.

25. If in the past an act of solidarity was the origin of Sainville, which moved our Sisters, today the Congregation in Latin America and the Caribbean seeks to be a witness to solidarity, through numerous services attesting to selflessness and mercy, advancement of the person, and commitment to people and their health status.

26. At present the service of *charity in health care* is a challenge for the Congregation, in view of the state of poverty in which most of the population lives—situations calling for direct action to defend and promote life, as a response of the Church and a commitment to the charism of the Congregation, in one of its apostolic directions.

27. There are realities which pose questions for our healthcare presence.

– Some deficiencies involve knowledge of social problems, getting in touch with the environment, motivation, creativity, and boldness in revitalizing the Congregation's mission in health, regarding which responses are not always in keeping with needs.
– More than half of the Sisters active in health care are over sixty. The young Sisters engaged in this apostolic work are a small percentage, and this has an impact on the availability of human resources and capacity for response by the Congregation.
– Pastoral work for vocations has not yet been taken up by all the healthcare communities as one of their responsibilities.
– A matter for real concern is the almost complete absence of this initial apostolic commitment of our charism in some Latin America and Caribbean countries where our Congregation is at work.
– In many of our Sisters in health care commitment to their own formation is weak, they lack the habit of studying, and there is insufficient intellectual discipline and theological and pastoral training.

C) Grounding on the Basis of Scripture, Theology, and Our Charism

God's Project for Humanity

28. For each man and woman God has a project for *life*, as we are begotten in the Truth, who makes us free through and for *love*, with the proposal of a *covenant*[6] between God and man. God carries out this project in the course of human history in his People, starting with each person in whom He dwells,

impressing his own image and providing a capacity for establishing new relations with the world *in freedom*, with other persons *in fraternity*, and with God *in filiation*.

29. In the harmony of these relations persons find the conditions conducive to leading their lives in accordance with their dignity, within a society structured around three inseparable levels: *faith*, which makes the Word effective; *communion* and respect for persons and nature; and *solidarity* and participation.[7]

In this perspective, God's People experiences Him as a God who is close, who walks with it and by his gestures and actions takes on the characteristics of a Father and Mother, showing concern for the least, the neediest and most abandoned.

30. Sin appears in the world and breaks this *Project of God* for mankind, and with it there arise illness, pain, and death; and yet man is not abandoned to his fate—*God the Father* offers this suffering humanity his liberation in *Christ Jesus*, the Son of God, who by his *Incarnation* took on the human condition and identified Himself with our poverty and limitation, except as regards sin.[8] The *Spirit* spurs this search for life and fulfillment.

31. Jesus not only is sensitive to human pain, but identifies Himself with those who are thirsty, cold, or sick. With gestures and words, by his life and mission, He announced the *Kingdom* and became a visible sign of the merciful love of the Father, for He came to reveal the Father to us. He forgave sins.[9] He is the Spirit's Anointed. For this reason, on being questioned by John's disciple's, He replied, "Go and tell John what you have seen and heard: the blind see, the lame walk, lepers are cleansed, the deaf hear, the dead rise again, and the Good News is announced to the poor."[10]

32. Jesus approached the sick, the poor, women, and all the excluded, not to reinforce their state of exclusion, marginalization, and pain, but to make them feel worthy, valued, accompanied, and understood in their condition, to invite them to rise up from their prostration, and take them out of a sinful situation. Through the Paschal mystery life, pain, and illness take on new meaning for man.

The Church Continues Jesus' Project of Liberation

33. Like Jesus, the Church exists to announce the liberating Good News. This announcement is her radical and integral commitment. Jesus' commandment for his followers and the Church includes preferential attention to the sick and afflicted. In sending his disciples as missionaries and apostles, He thus said to them expressly, "God and proclaim that the Kingdom of Heaven is near. Cure the sick...."[11]

34. The power to heal, to restore health, is a charism and ministry within the Christian community; it is a sign of the proclamation of the Good News of life and salvation in Christ. This charism has its Gospel model, the Good Samaritan, proclaimed by Jesus. The Church, aware of her mission, must approach the sick like the Good Samaritan and, identifying with them, make them feel themselves to be persons, restoring them to their familial and social environment.[12]

35. In her prophetic mission the Church is called to announce the Kingdom is a special way to the sick and excluded, the suffering, and denounce sin, even in its historical, social, political, and economic roots, the causes of illness and death, of a loss of the value of life, and of neglect of human dignity. Her message is aimed at man, the lord of creation, whom she invites to transmit life consciously and responsibly, to administer, enjoy, care for, defend, and protect it in keeping with God's Project.[13]

36. The Church as a Christian community announces the Good News of Salvation when it opts for life and increases hope in building a more humane, fraternal world, a manifestation of "the new heavens and the new earth." *Mary* appears as the model and figure of this Church committed to the Kingdom—the mother of all reborn to life, the mother of the One who is *Life* and through whom all live. On giving birth to Life, Mary to a certain degree regenerated all those who were to live through her.[14]

37. Within God's Project, taken up by the Church in her pastoral action, health is seen as a gift and as a fact conditioned by social, historical, political, and economic factors which situate it beyond observable biological phenomena. It is the result of man's interaction with nature and living conditions; health, illness, suffering, and death are thus limit experiences placing man before the mystery of existence and giving the Church the chance to make the salvation offered by Christ present through pastoral care.

38. *The Health Apostolate*, seen as the action of the whole People of God, committed to promoting, caring for, defending, and celebrating life, makes the saving mission of Christ Jesus present in society through

– *the pastoral care of the sick*, as an expression of solidarity towards the suffering so that, starting from their condition, they will cooperate with the historical project set before them and become witnesses of the redemptive value of suffering;
– *institutionally-based pastoral care*, as a contribution to God's salvific plan for man: in evangelization and humanization affecting science and technology, defense of life and human dignity, and training for health care:
– *community-based pastoral care*, as an educational, participatory, liberating, and transforming process in communities and social groups, with a view towards fostering a culture of life enlightened by Gospel values;
– *pastoral care of the family*, representing the Church throughout the course of "health and illness" as a true school of humanity and a sanctuary of life.

The parish, as a center for coordination and pastoral stimulus, orients evangelization fostering health and life.

39. Through this integral view of man offered by the Church's ministry, health is situated before the paradigm of quality of life, illness, suffering, and death—as opportunities presented to persons for an encounter with themselves and their brothers and sisters—are seen to be paths to discovering truth and, in a dynamic of hope, returning to the God of life, who "restores all things in Christ Jesus."

Our Commitment
to God's Project
Through the Charism
of the Congregation

40. Marie Poussepin, a woman "inspired by Providence," a "Social Apostle of Charity," wants her Institute to be dedicated to the imitation of the Charity of Jesus Christ, through practicing the works of mercy, especially by way of "the corporal and spiritual care of the sick poor in the countryside or at the hospitals entrusted to them."[15]

41. The experience of God, which is transforming and profound, enables us to discover a new language for reaching our brothers and sisters; we are able to perceive worldly events and the silent cry of the men and women of our time as God's calls and, with originality and boldness emerging from a contemplative spirit, offer the response of mercy required by a given moment in history.

42. Marie Poussepin's missionary action becomes effec-

tive in the *Community of Apostolic Life*, a community which is built up day by day, starting from the Word, with the Eucharist as its source, Our Lady as its model, and brotherhood as its expression. Through this Community service to life and health is a ministry whose aim is exclusively to extend the Kingdom, wherein the poor are the object of a preferential option.[16]

43. In concrete, observed reality our Mother Foundress was able to discern signs and found channels in the health orientations and policies of her time for the *inculturation of the Gospel in defending life and promoting health through her charitable service*.

44. Marie Poussepin's charitable service in health care presents specific characteristics.
- She cared for the sick in an edifying manner, for she was filled with charity.[17]
- She showed exquisite charity in caring for her sick Sisters.[18]
- When she was faced with patients suffering from repugnant diseases, she reserved this service for herself.[19]
- Visits to the sick were aimed at practicing the spiritual and corporal works of mercy.[20]
- She regarded care of the sick as an *art* requiring competence so as to provide greater service to Jesus Christ in the sick.[21]
- She asked her Sisters to serve the sick as a notable witness to charity, showing no displeasure, trying to be more useful to their souls than to the care of their bodies.[22]
- With prudence and boldness she organized the different forms of presence which enabled her community to expand rapidly.
- With a capacity for risk-taking and prophetic foresight, she anticipated the training and qualification of her Sisters as a duty to justice in carrying out their mission "wherever the Church calls us and wherever our brothers and sisters need us."[23]

45. In Marie Poussepin's vision, a mission is not lucrative, but is fulfilled with selflessness and mercy. Sisters live by their work, seen as a vocation and not as a mere activity; it is a means for evangelization enabling the community to share and show solidarity with the poorest.[24]

46. The Congregation, faithful to the Project of the Social Apostle of Charity, on the threshold of the fourth century of its history seeks to continue the evangelizing work begun at Sainville for the sake of dignifying man and promoting life and health.

47. Today, as at the beginning, this work must be marked by the seal of discernment of reality, the contemplative study of God's calls through events, the selection of priorities and methods in accordance with the criteria of the Gospel and our charism, and faithfulness to man, the Church, and our founding principles. Charitable service in health care—performed with mercy, timely intelligence, responsibility, and a capacity for innovation—must offer the Church's apostolate a well-honed instrument with which to work towards the liberating project proposed by the Lord of Life.

48. In health care, each Dominican Sister of Charity of the Presentation in her charitable service conveys the presence of the Church as a witness to the Gospel values; in her daily work she adopts the orientations of Christian ethics; by her actions and words she evangelizes in the manner of Jesus and in keeping with the charism of Marie Poussepin. In an increasingly pluralistic world, she shares her mission on behalf of life with *lay people*, to whom she conveys her *spirituality*.

49. Faithfulness to God's Project, revealed in his Word, and the creativity needed to prolong charitable service in health care over time make a series of demands on each Sister and each community, requiring:
- priority attention to God which is integral (C 38);
- an attitude of constant conversion (C 15);
- solid formation grounded in the Word of God and the charism of the Congregation (I.P.);
- intelligent, critical, and merciful knowledge of our time;
- professional updating (C 39);
- a capacity for embracing new places and leaving them as a condition for the itinerant life of the Gospel (C 52).

50. *Integral attention to men and women and the option for life* are a call to the Congregation in its fourth century, on the threshold of the third millennium of Christianity and in the light of the *Beatification of our Mother Foundress*, so that, with new dynamism it may respond to health care today, inculturate the Gospel through prophetic service, and promote solidarity as the "new name of charity."

51. By its international character the Congregation feels committed to "a new apostolic impetus," a manifestation of passion for God, for the Kingdom, and for man which finds its dynamic in the Incarnation in order to say to men today, "We announce to you concerning the word of life what our hands touched" (*1 Jn* 1:3).

D) Our Mission

52. We are Dominican Sisters of Charity of the Presentation of the Most Blessed Virgin active in health care, where we seek *to announce Jesus Christ with new apostolic impetus marked by solidarity and inculturation and a commitment to justice and defending and promoting life*.

As a Congregation in Latin

America and the Caribbean active among the neediest, in health facilities and training centers, parishes and dioceses, and interdisciplinary teams we wish to offer charitable service based on the Gospel values, respect for life and nature, and recognition of human dignity, performed with love, mercy, selflessness, communion, universality, and timely intelligence.

In local communities, cooperating with lay people, we seek to continue the Missionary Project of Marie Poussepin today, promote life and health by our attitudes and actions, allow ourselves to be evangelized, and evangelize persons and structures so that the Kingdom will emerge and our charism will continue to be embodied in cultures and possess the power of the call "Come and see."

E) Challenges

53. Changing reality, discerned in the light of Gospel demands, the Church, and the charism of the Congregation, presents us with certain challenges where the life and vigor of the Gospel and Marie Poussepin's Project are at stake.

– If we fail to respond boldly and creatively to the demands of today's world by way of solid training, the charism of the Congregation in health care will lose its dynamism and applicability.
– If we fail to commit ourselves through conscious, planned, and reasonable action to defend life and human rights, our mission will not be faithful to the Gospel, to Marie Poussepin's insight, or to the present time.
– If we fail to join with lay people in serving health and life on the basis of ethical and Christian principles, our presence in health will lose its evangelizing dynamism.
– If we fail to opt for a health apostolate which is organized, dynamic, bold, and open to changes revitalizing our missionary presence, our involvement in health care will lack meaning for evangelization.

F) Priorities and Strategies

54. **Solid training for Sisters**

– Strengthen theological and pastoral training rooted in the Word, with human, ethical, spiritual, and biblical dimensions.
– Fortify fraternal life as a sign of community and commitment to our mission.
– Promote qualifications and updating among the Sisters in the areas affecting health care.
– Devote new attention to *health culture for the people*.
– Analyze health policies and get involved with them from a Gospel standpoint.

55. **Defending life and human rights**

– View health care critically, in the light of the Gospel.
– Rescue human and ethical values in health service.
– Make the prophetic announcement a commitment to health, the quality of life, and the participation of citizens.
– Promote and take part in interdisciplinary teams fostering a culture of life.
– Give priority to situations involving poverty, need, and exclusion.

56. **Lay people serving life and health**

– Rediscover a vocation to service and a commitment to defending and promoting life and health along with lay people.
– Share our spirituality with lay people who engage in charitable service in health care along with us.
– Recognize and give preference to the family and the dignity and preparation of women as bearers of life.
– Get involved personally and as a community in pastoral attention to vocations as an option of the Congregation and a way to keep our charism alive.

57. **Organization of the health apostolate**

– Foster the Gospel's penetration into health care.
– Experience passion for our vocation and the world in our health service, rendering attractive the radical following of Jesus Christ.
– Rediscover value of the mass media and their use to defend and promote life.
– Organize and activate the health apostolate with lay participation at the facilities where we work.
– Experience solidarity with the sick and their relatives, both at facilities and at home.
– Rediscover a dynamic which evangelizes health care with our elderly and ill Sisters.

G) Applying and Evaluating the Project

58. This Project should be applied in each Province in the following stages.

– Those responsible for the health mission in each Province or Vice Province must enkindle in their Sisters *motivation and commitment to spread, apply, and execute the Project*.
– Each local community and Sister must feel responsible for *assimilating and studying* this document, particularly those that have been entrusted with this apostolic orientation of our charism.
– On the basis of the guidelines of this Project, each Province and Vice Province in Latin America and the Caribbean, according to its circumstances, shall work out its specific projects. It is up to the local community to *give life to the project for the health ministry*.
– Those responsible for the health mission at each facility should seek the means for an *annual evaluation* of the steps taken to apply the Project and make necessary corrections.

59. On an interprovincial level, at the meeting held every two years the Provinces

and Vice Provinces of Latin America and the Caribbean shall present a *report on achievements and difficulties encountered*, along with suggestions for current action.

At these meetings *the means shall be established* to ensure a dynamic process and unified criteria in pastoral action at the same time as goals are set for the next stage.

Dominican Sisters of Charity
of the Presentation
of the Most Blessed Virgin

Notes

[1] Encyclical *Evangelium Vitae*, n. 79
[2] *Giov* 10, 10
[3] Celam. Pastoral de Salud, II Encuentro Latinoamericano y del Cariba n. 264. Quito, Ecuador, Nov. 1994, pag. 10.
[4] GREGORIO IRIARTE O.M.I., *Neoliberalismo - sì o no?* Ed. Paulinas Medellin 1995, pag. 41.
[5] UN, *Declaration on Human Rights*, Art. 22 e 25.
[6] *Dt.* 30, 19-20
[7] *DP* 317 e 322
[8] *Fil.* 2, 6-8
[9] *Mc* 2, 9-11
[10] *Mt* 11, 4-5
[11] *Mt* 10, 7-8
[12] *Lc* 10, 25-37
[13] *Evangelium Vitae* n. 78-81
[14] *Evangelium Vitae* n. 102
[15] *Regl.* I
[16] C.I.
[17] *Sumario de la Positio*, trad. H. Margarita de la Encarnación ed Copiyepes Medellín 1986. Pag. 97.
[18] *Reglamento para las Hermanas de Sainville*, trad. Suor Margarita de la Encarnación, Tours, 1985, cap. XXV
[19] *Sumario Positio*, op. cit. pag. 97
[20] *Regolamenti* op. cit. Cap. XXXVI
[21] *Ibid.* Cap. XXXVI e XLII
[22] *Regole Generali*
[23] C. 51
[24] *Reg.* XXVI

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Activity of the Pontifical Council

Eighth Congress of the European Federation of Catholic Medical Associations

Pompei Meeting

Chronicle

To Serve the Suffering Is a Mission

A Letter from Cardinal Angelo Sodano, Secretary of State, to Cardinal Fiorenzo Angelini
Vatican City, May 10, 1996

Your Eminence:

On the occasion of the Eighth European Congress of Catholic Medical Associations, to be held in Prague in the first ten days of June 1996 and devoted to "Medicine Today and Our Image of Man," the Holy Father wishes to express his satisfaction over this meeting, which is especially significant because of the presence of groups of physicians from the countries of eastern Europe who have recently formed Associations belonging to the European Federation. Their attendance cannot fail to make a concrete contribution not only to the progress of medicine, but also to the consolidation of cooperation among European physicians.

The Supreme Pontiff, deeply sensitive to the need of the present time, does not tire of stressing the importance of research for scientific progress in a field which is so fruitful and rich in promise as is medicine. This research is certainly supported by the light deriving from the fundamental ethical principles formerly recognized and promoted by pre-Christian antiquity, but it is, above all, from the splendor of the truth of the Christian faith that it draws fullness on both a natural and supernatural level.

As Good Samaritans of our time, health workers drawing inspiration from the Gospel are able to "pause"—or, rather, "be moved" (cf. *Lk* 10:33)—before their suffering brothers and sisters and bend lovingly over them, to take care of their wounds and assume responsibility for their situation. Those suffering physically or spiritually are weak and feel alone: they do, indeed, need medicines and care, but also comfort and spiritual solidarity. To serve those suffering is thus not just a social profession, but is also a "mission" consisting of becoming the neighbor of the sick, helping them not to lose heart and to face trials serenely.

As the Holy Father affirms in the Apostolic Letter *Salvifici Doloris*, "The eloquence of the parable of the Good Samaritan, like that of the whole Gospel as well, is this in particular: man must feel *personally called* to witness to love in suffering. Institutions are very important and indispensable; however, no institution can alone replace human love and human initiative, when it is a question of dealing with the pain of another. This refers to physical sufferings, but is even more valid when the multiple moral sufferings are involved, and, first of all, when it is the soul that suffers" (no. 29).

The physician, today more than ever, is called to discern the very image of Christ in the image of the sick, always recalling what the Lord said: "I was sick, and you visited me" (*Mt* 25:36). All of this evidently requires each individual's ability to place personal competence at the service of others, regardless of their country, race, or ideology.

At the side of those suffering may there always be a loving heart, a heart able to beat in harmony with that of our brothers and sisters in difficulty; a heart ever concerned about the needs of others. And this is because of the deep respect each of us is bound to feel for the sacred gift of human life, for its inviolable nature.

His Holiness expresses the wish that the scientific progress of professors and health professionals—to which the augmenting and perfecting of medicine are entrusted—will also be accompanied by a vigilant awareness of the lofty mission of protecting human life, created by God and redeemed by Christ. The Supreme Pontiff, John Paul II, also expresses the desire that there will be exemplary fidelity to the Magisterium of the Church, fruitful cooperation with Bishops, placed by the Holy Spirit to govern the People of God, and, finally, an increasingly generous impetus in stimulating a Christian approach at health facilities.

With these wishes the Holy Father willingly imparts to Your Eminence and to the speakers and organizers of this meeting his auspicious Apostolic Blessing, which he readily extends to all those participating and their families.

I take this occasion to convey my warmest personal regards.

Cardinal ANGELO SODANO
Secretary of State of His Holiness

Witnesses to Our Serving Life

A homily by Cardinal Fiorenzo Angelini at the opening of the Eighth Congress of the European Federation of Catholic Medical Associations in Prague, June 1996

The liturgy in this period is under the sign of Pentecost.

With the descent of the Holy Spirit (*Acts* 2:4-17), the Church had her beginning.

The Holy Spirit, or Spirit of God, is the supernatural power whereby God, entering into man, conveys to him a superior strength. Indeed, once they had received the Holy Spirit, the Apostles became bold witnesses to Christ (*Acts* 4:31), precisely because the Spirit is the power whereby Jesus gives spiritual life to those who believe in Him (*Jn* 7:37-39).

A power—as St. Paul attests—which even makes men able to accomplish prodigious healings (*1 Co* 12:10).

May today's liturgical celebration at the heart of your Congress be an occasion to meditate on a special gift which faith attributes to the Holy Spirit: the gift of wisdom.

Wisdom is to science what love is to knowledge.

God is love (*1 Jn* 4:8-16), and love is the first gift, the one containing all the others. God has poured this love into our hearts by means of the Holy Spirit, who has been given to us (*Rm* 5:5).

Few professions in everyday experience sense as much as medicine does the need for requisites extending beyond mere science and knowledge to enable men to explore not only the physical condition of those we are called to assist, but their heart and their psyche.

Wisdom, while opposed to false science, is the indispensable crown of true science.

History teaches us that purely human knowledge and science, unable to look beyond man's brief trajectory on earth, translate into foolishness and weakness (*1 Co* 1:17-29, *Rm* 1:22). And today, when scientific progress has reached goals which were once unimaginable, with dramatic immediacy we observe the need for a wisdom enabling us to transform science into living awareness of man's supernatural destiny. But this is possible only if science, through the gift of wisdom, is able to become a channel of love serving man.

As the science of love, wisdom is also a source of unity, a unity which—for you, that come from different countries and speak different languages and belong to different schools of thought—is all the more necessary because your mission is singular and unmistakable and your—indeed, our—witness must be singular and unmistakable.

At this time we ask the Holy Spirit for the gift of being witnesses *together* to our service to life, committed *together* to making the truth concerning man and his condition revealed to us by Christ credible.

Let us meditate on these very profound and relevant words of the great master of doctrine, St. Cyril of Alexandria. He writes, "All of us who have received the one same Spirit—that is, the Holy Spirit—*are united to one another and to God*. Indeed, though, when taken separately, there are many of us, and in each of us Christ has the Father's and his own Spirit dwell, the Spirit is, however, one and indivisible. He joins in unity spirits that are different from one another and in Himself makes all into a single reality. As the power of the holy Humanity of Christ makes all who are in Him concorporeal, in the same way the one and indivisible Spirit of God dwelling in all leads all into spiritual unity" (*Commentarius in Johannem*, 121).

This is the thought I would like the memory of the meeting now being held to remain linked to: awareness of the need for our science to be enriched constantly by the divine gift of wisdom.

In one of the most frequently quoted passages—though perhaps not sufficiently meditated on—in the Council's *Constitution on the Church in the Modern World* we read, "Our time, more than past centuries, needs this wisdom so that all our discoveries will become more human. The world's future is in fact in danger, unless wiser men are brought forth" (*Gaudium et Spes*, 151).

With the Church we invoke the Holy Spirit, repeating the words of the sequence devoted to Him: "Without your divine presence, we are nothing, and nothing in us is pure. Cancel out our guilt, free us from spiritual aridity, heal what is sick in us. Bend what is arrogant in us. Warm what is cold. Turn to good what leads us to stray from the straight way" (*Sine tuo numine, nihil est in homine, nihil est innoxium. Lava quod est sordidum. Riga quod est aridum. Sana quod est sauciu m. Flecte quod est rigidum. Fove quod est frigidum. Rege quod est devium*). Amen.

FIORENZO Cardinal ANGELINI

Modern Medicine and Our Conception of Man

Cardinal Fiorenzo Angelini's Opening Address at the Eighth Congress of the European Federation of Catholic Medical Associations held in Prague, June 1996.

First of all, a cordial greeting to all participating in this Eighth Congress of the European Federation of Catholic Medical Associations. I particularly greet the Presidents of the different Associations, the Ecclesiastical Assistants, the Board Members, and those responsible for governing and organizing within the respective national Associations.

I also express my deep gratitude for having been invited to open your sessions with some reflections on a subject—the theme for your Eighth Congress—which poses questions for us on the indissoluble bond between *science* and *conscience* and between *professional experience* and the *guiding principles* which must inspire it.

The topic alluded to is vast, but is anything but general. Its core goes to the heart of a problem which is increasingly noted, involving a science, medicine, whose forward progress is not only unstoppable, but which is experiencing surprisingly rapid growth.

Just as, when stepping into a river, we are never bathed by the same water, so we might say that in medicine the scene constantly changes—or, rather, is struck by ever new light.

Medicine, as "care of man," both etymologically and actually, is one of the most lively, universal, and gratifying sources of hope; it was in the past, and is such today in particular, if we consider that modern medicine has also set out on the so-called information highways, along which it cannot fail to reach ever new and more satisfying goals.

In relating modern medicine to our conception of man, we might state spontaneously that whereas medicine represents the dynamic element, our conception of man represents the static one.

This is only partially true: it is certain in the sense that as a rearguard of medicine—as happens, moreover, in every other branch of knowledge—there is always some conception of man and his destiny. It is not true if we should entertain the illusion that, in terms of discursive formulation and the penetration of concepts, even the human and Christian idea of man we profess has not witnessed intrinsic progress.

And you, belonging to different cultural traditions, are fully aware of the internal dynamism which accompanies the presentation of immutable principles.

Personally, I am convinced that precisely in this nebulous ambiguity there lies one of the reasons for a persistent incomprehension, even in our environment, of the relation between medicine and morality, between problems and solutions identified by medicine and questions of a rational and ethical order posed by them.

This is demonstrated by, among other things, the tendency or temptation to enclose oneself in one's own systems of thought and even to become alarmed in sterile fashion at terminological innovations or ideological formulations which seek to adapt to man's forward journey, without losing sight of the immutable starting point.

Medicine and the conception of man are both moving in the direction of a progressive approach to the *mystery that is man*. There is thus talk of the mysteries of science, in the sense that science, if rightly understood, is a gradual deepening of knowledge of the human being in the more general framework of knowledge of the universe. At the same time speculative reflection—guided by sentiment as well—on man is revealing increasingly recondite forms of access to him.

If, in fact, we try to replace the phrase "conception of man" with the phrase "conception of human life," we at once discover that precisely in the notion of life both the service which medicine is called to perform and that which is the responsibility of philosophical and theological reflection meet, almost to the point of fusing.

The techniques medicine avails itself of can enable man "to take his destiny into his own hands," but they also expose him "to the temptation to go beyond the limits of a reasonable dominion over nature."

Medical science and technology, especially with today's progress, in being ordered towards man, who is their artificer, either draw nourishment from man's deepest values and place themselves at his service or go against man. It would, indeed, be contradictory and even illusory to claim the moral neutrality of scientific research and its applications.

Now then, precisely the impossibility of this neutrality posits continuous, bold, and also firm renewal in carrying forward—at the same time and harmoniously—the progress of medical science and the lucid presentation of our conception of man.

What is, then, the notion which, with no presumption, but with sincere intellectual humility, we might term our "conception of man"?

Let us state at once that it is not *ours*, in the sense that it is

necessarily contrary or opposed to that of others. It may be, but that is not the starting point for defining it.

Our means, above all, that we believe in it and seek to make it a criterion for consistency in our action and witness for those who approach us.

Our in the sense that it must also be clear, unmistakable, and openly recognizable for all.

Our, finally, because we must feel committed to reinforcing it, to making it an increasingly solid and deeply-rooted guideline for conduct.

As I stated at the outset, in a short time we cannot adequately describe and illustrate what we call our conception of man. There are, however, some indispensable observations which I feel may be pointed to as constituting, so to speak, the framework for Christian anthropology.

And it is precisely these observations which, when placed alongside the concept of modern medicine, shed light on its scope and demonstrate its close link to the conception of man.

When brought together into a single formulation or definition, these points tell us that *man is an image of God, seeks happiness, and is endowed with freedom and responsibility, which make him a subject capable of morally good acts, for which the criterion and judge is a rightly formed moral conscience*.

The *starting point* is this: man, as "the only creature God has wanted for its own sake," fulfills himself in seeking and loving God, of whom he is a most perfect image.

Reflection—not only Christian reflection—in its highest manifestations has reached the conclusion that the world and man do not possess in themselves either the first principle or their ultimate end. Something transcends us—something and Someone "whom we all call God."

The desire for happiness is rooted in this transcendent origin. In the conception of this desire and in the ways to satisfy it the paths of knowledge and practice diverge.

Indeed, we all know that happiness is sought in wealth or well-being or human glory or power or in any, even most noble, activity which does not, however, transcend our fragile condition; but we also know that in these goals man does not find the happiness he aspires to, full self-realization.

Unfortunately, we neglect verifying this, but it is implicit in things.

If we and our life issue forth from God—indeed, from an act of love by God—it is by traveling this road that we may bring our personal realization to maturity.

This is true to the point that we even call mistaken or inappropriate goals "idols," precisely because we instinctively need to fulfill ourselves in something and someone with the attributes of the Divinity.

Endowed with freedom and responsibility, man is a moral subject, capable of morally good acts, for which a rightly formed conscience is the judge.

That the freedom and responsibility with which we are endowed may also bring us to do evil is so evident that it needs no demonstration. No less evident, however, is our capacity to perform morally good acts by virtue of our freedom and responsibility.

Conscience is the supreme criterion for human action, provided it is rightly formed.

The problem clearly becomes complex here, especially in relation to certain life choices.

I would say, however, that precisely by comparing the aforementioned conception of man with medicine in general, and with modern medicine in particular, we discover that medicine can even be a guide to maintain ourselves firmly within the proper Christian and Catholic conception of man.

Indeed, medicine is, above all, service to life, which is fully served when we do not limit ourselves to bodily reality alone, but deal with life and the dignity of the human person as a whole.

And it was precisely when speaking at a Roman hospital that John Paul II touched upon the subject of the relation between medicine and our conception of man, affirming that if life is a gift of God, it must constitute the final, definitive reference point which must be looked to continually in exercising the art of medicine at all stages.

And in this regard I would say there is little difference between modern medicine and medicine in every period.

I have met with patients and doctors in many parts of the world: in modest clinics in the heart of Africa, Latin America, and Asia, as well as at large hospital complexes in Europe and North America. I have seen rudimentary and sophisticated techniques being applied. Always, as regards the factor leaving an indelible mark upon me, the one, immutable fact was the need for life and the need for medical action to meet this need for life—doctors and patients struggle together for life.

In other words, the acid test of our authentic, truthful, consistent conception of man is provided by the way in which, availing ourselves of the achievements of modern medicine, we are able to serve life—by preventing illness, by offering care for infirmity, and by relieving suffering when maladies are incurable.

If, however, in general right conscience is formed almost automatically when medicine is practiced with humanity, problems awaiting a response or at least deeper examination are not lacking. It is in the face of these that we are called uninterruptedly to take an interest in our human and professional preparation, for precisely in the practice in the medicine problems reach dimensions which call for our intelligence and also our sensitivity.

The problem of fostering humanity in medicine is posed precisely because of the need for a close bond between reason and feeling, between mind and heart.

I believe that *The Charter for Health Care Workers*, which has been received in such a satisfying manner by

Catholic health workers—and also among doctors, researchers, and scientists who are not Catholic—constitutes a valuable tool for clarification and, allow me to say, for inner peace, if its guidelines are accepted.

May every Catholic physician regard it as a manual, seeking to study it daily.

There certainly exist, however, cases, situations, and aspects in your activity as individuals and associations which can prompt questions which you feel unable to answer or which you regard as unresolved or insufficiently studied or dealt with in the documents of the Church's solemn and ordinary Magisterium.

Well then, precisely for the solution of these problems John Paul II has instituted the *Pontifical Academy for Life*, whose aim is to "study and provide information and training regarding the main problems of biomedicine and law connected with the advancement and defense of life, especially as they relate to Christian morality and the directives of the Magisterium of the Church."

May it be the task of your national Associations and of the European Federation itself to formulate—by way of scientific meetings or congresses—postulates or questions to be forwarded directly to this very expert and representative organism so as to receive an answer to specific needs.

This Eighth Congress of yours can provide a valuable opportunity to study such initiatives, which also have the advantage of accustoming us to closer cooperation, without which our witness as Catholic doctors cannot—as, however, it must—be accepted within the universal effort of medicine to serve man.

The Youthfulness of Old Age

Remarks by Rev. José L. Redrado at the Pontifical Sanctuary of Pompei, Italy, on July 11, 1996, for a meeting on integrated service networks for geriatric care.

1. In reflecting on the title to give to my address and the conclusions of this symposium on geriatric care, I came across the phrase "youthfulness of old age,"[1] which impressed me, for it is a phrase charged with meaning.

It has been said that man is born old and then gradually becomes young, because the youthfulness of old age is altruism, the aspect of giving and of no longer receiving.

2. A second idea which impressed me involved observing the great number of phrases, slogans, and sayings devoted to old age.

* It has been called the golden age, the age of retirement.
* For Cicero the ideal was "to grow old without turning sour," like good wines.
* We all know Juvenal's mode of expressing how he wished to reach old age: *Mens sana in corpore sano*.
* A Greek philosopher said, "Old age begins when memories have more weight than hopes."
* In the Middle Ages, the Salerno School gave the following advice to reach old age: "Honest, orderly life. Taking few medicines. Strive in every way not to become upset about anything. Moderate food intake. Exercise and pastimes.
* And the psalmist exults with joy and hope when he says, "In old age they will still bear fruit..." (*Ps* 91:15).

3. In contrast to our culture, which marginalizes, in ancient times they enjoyed great esteem and were placed at the head of families and groups; to some extent they were responsible for administering justice and preserving traditions.

Many of these ideas have been conserved in Sacred Scripture, especially in Exodus (chapters 3, 12, 17) and Numbers (chapter 11): "'Gather together the elders of Israel....' Moses called together all the elders."

Similarly, as reported in the New Testament, the elders had responsibilities and formed part of the Synedrium (cf. *Ac* 11-21).

The adages in Sacred Scripture in this respect are famous.

* Life is a gift of God, and a promise of long life is made to those honoring their parents (*Ex* 20:12); those fearing the Lord prolong their lives (*Pr* 10:27). "Their children's children are the crown of the elderly; their parents are the honor of children" (*Pr* 17:6). "Abraham died in a happy ripe age, old and full of days..." (*Gn* 25:8). He died in peace, conscious of having led a full life, like the other elder of the New Testament, Simeon, who exclaimed, blessing God, "Now, O Lord, let your servant go in peace, for my eyes have seen your salvation..." (*Lk* 2:29-30).

And it is precisely in St. Paul that we find both the exhortation and the personal example: "Let the elderly be sober, dignified, prudent, and firm in faith. In the same way, let elderly women behave in a manner worthy of believers and not be given to cursing or slaves to excessive wine; rather, may they be able to teach goodness to educate younger women in love for their husbands and children and be prudent, chaste, and devoted to the family" (*Tt* 2:2-5).

"We do not get discouraged, but, even if our outward man is falling into decay, the inner one is being renewed day by day" (*2 Co* 4:6).

"As for me, my blood is about to be shed as a libation, and the time has come for me to depart. I have fought the good fight. I have finished my race. I have kept the faith" (*2 Tm* 4:6-7).

4. It escapes no one that we are moving towards a society of the elderly![2] Sociological studies amply illustrate the aging of our populations.

I will not insist excessively, but simply point to some notions and figures in summary fashion which will later help me to draw certain conclusions.

* In the year 2000 two-thirds of the elderly will be living in developing countries.
* In 2020 total population in these countries will have increased by 95%, whereas the number of elderly persons will have increased by 240%.

THE TWENTY COUNTIES MOST AFFECTED BY AGING
Projections for population increases among those 60 and over (1980-2020)

Ranking 1980	County	Population 1980	Over 60 1980	Population 2020	Over 60 2020	Ranking 2020
1	China	996.1	73.6	1,436.3	238.9	1
2	India	688.9	44.6	1,186.3	149.7	2
3	U.S.A.	227.7	35.8	304.4	66.9	4
4	U.S.S.R.	265.5	34.7	358.1	69.3	3
5	Japan	116.8	15.0	132.6	34.7	5
6	Germany	61.6	11.9	54.7	15.7	8
7	U.K.	55.9	11.3	56.1	13.5	13
8	Italy	57.1	9.8	57.5	14.5	10
9	France	53.7	9.2	58.3	14.3	11
10	Indonesia	151.0	8.0	262.1	30.1	6
11	Brazile	121.3	7.5	233.8	28.4	7
12	Spain	37.4	5.6	45.4	9.2	18
13	Poland	35.6	4.7	44.6	9.7	17
14	Bangladesh	88.2	4.6	206.0	12.6	15
15	Pakistan	86.1	4.0	198.1	13.9	12
16	Mexico	69.4	3.6	146.0	14.6	9
17	Argentina	28.2	3.4	45.6	6.7	20
18	Vietnam	54.2	3.3	103.4	9.8	16
19	Canada	24.1	3.3	32.5	7.7	19
20	Nigeria	80.6	3.2	301.8	12.8	14

THE ELDERLY IN THE EUROPEAN COMMUNITY AND MEMBER STATES 1991

	60 and over		80 and over	
	thousands	%	thousands	%
EUR 12	68,576	19.9	11,936	3.5
Belgium	2,062	20.7	353	3.5
Denmark	1,046	20.3	192	3.7
Germany	16,264	20.4	3,011	3.8
Great Britain	11,931	20.7	2,128	3.7
Greece	2,049	20.2	323	3.2
France	10,953	19.3	2,151	3.8
Ireland	538	15.3	79	2.2
Italy	11,888	20.6	1,878	3.3
Luxemburg	73	19.1	12	3.1
Holland	2,611	17.4	437	2.9
Portugal	1,798	18.2	247	2.5
Spain	7,362	18.9	1,125	2.9

5. From the figures in the tables two things appear clearly.

a) The population over 60 will go on increasing; in 2020 there is expected to be one elderly person for every two active people.

b) It does not seem that living conditions for the elderly will improve in this period. Much depends on a nation's overall improvement.

Living conditions for the elderly are estimated according to certain indicators, such as total consumption, housing, and comfort.

The concepts of improvement of living conditions and quality of life at all levels—economic, medical, social, personal (needs, desires, values)—come into play here.

Quality of life emerges from the contrast between reality and expectations—that is, from an evaluation of the distance separating the two. Quality will be regarded as satisfactory when the distance perceived is not great.[3]

Conclusions

1. A culture providing ever more assistance for this final stage in life must be created. After the writing of a whole book during life, this last chapter must be full of enthusiasm, joy, hope, a feeling of having done one's duty, an awareness of having been useful, of having cooperated, helped, and contributed to making history.

It is a time for cultivating other values which we have previously neglected or have not experienced sufficiently: friendship, reading, reflection, music, art, prayer, remembering and celebrating the things making us happy, such as anniversaries, and preparing to die with serenity and dignity.

2. Longevity and quality of life are an open challenge presenting itself to society and the biomedical sciences. Sociology tells us how great a leap has been made in life expectancy! How much average age has increased! It is a great achievement. Now it is a matter of giving life to years, attaining greater physical and mental health in this final stage of life.

As Pope John Paul II says,[4] "Indeed, it is not enough to satisfy the primary needs connected with longevity: it is necessary to take into account the demands posed by the personal dignity of the elderly, making available to them the set of measures enabling them to lead a life accompanied by activity suitable to their age...." (No. 2).

The Pope continues, "The close relation which in the very title of your Conference you have rightly established between longevity and quality of life leads us to understand that we should regard it as an inadequate achievement to increase life expectancy on a percentage basis if the quality of life does not keep pace. However, to pursue this objective effectively it is necessary to involve the whole body of society so that there will come to maturity a new sensitivity to this problem. Preventive and curative medicine must be accompanied by wide-ranging action foreseeing institutions and facilities able to open up for the elderly the areas of culture, education, and the most varied activities...." (No. 7)

3. It is becoming increasingly urgent to improve our social attention to the elderly by creating new forms of care, for we are faced with a society rewarding health, youth, beauty, usefulness, and efficiency, values which are hard to find in the third and fourth age groups.

It is necessary for society to change its mentality regarding the elderly, avoiding separation from the family as much as possible and integrating them as far as they are able—for example, in forms of volunteer work, in personal training adapted to their age, and in many other ways helping the elderly to live serenely and give meaning to their final years. They must be helped to accept their limitations, but also to feel useful, helped to esteem friendship, to be a sign of reconciliation between generations, to be a sign of happiness, prudence, judgment, and counsel. It is necessary for society to take advantage of the immense experience obtained over the years.

In an increasingly dispersed and impersonal society, thought should be given to creating social and health facilities permitting proper, specific attention to the elderly: home care, care-oriented residences, day and night hospitals, etc.

Pope John Paul II, in his address to participants in the Third International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers,[5] said, "Today, in fact, rejection of the patriarchal family model, especially in the rich countries, has fostered the growing phenomenon of entrusting the elderly to public or private facilities, which, in spite of good intentions, generally are not able to help them completely to overcome the barrier of psychological isolation and, above all, family marginalization, depriving them of the warmth of the family, of interest in society, of love for life. It is thus necessary to create facilities to receive them which increasingly take into account these psychological and spiritual needs of the human being, on which the 'quality of life' of those who have reached this stage depends to a decisive degree...."

We must, however, forcefully affirm that this is not the ideal solution. The objective towards which we should be oriented is for the elderly to be able to remain in their homes, relying, if necessary, on adequate forms of home care. Public involvement in this regard may be accompanied by volunteer action, with the contribution of initiatives drawing inspiration from the teachings of the Catholic Church, as well as from other religious and humanitarian movements deserving respect and gratitude (No. 4).

4. To prepare and educate the young and families in solidarity, acceptance, understanding, and help.

In a world of selfishness,

stress, and exaggerated stimulus of material values it is hard to leave room for others; there result the marginalization and aggressiveness we are experiencing in our societies.

The new generations should be told that they will be tomorrow's elderly; if they want to be cared for properly, they must begin now to create a culture of solidarity manifested in concrete gestures, deeds involving closeness and love.

"...Humanity and the Church today must learn to live alongside the elderly. Perhaps this is one of the most important new experiences of mankind which today's society must undergo.

"The prolongation of life has changed the proportions of society, modifying the balance among the members of our families and generating new moral demands for us. All of this is a result of an increase in the number of the elderly. If we count them, it turns out that they represent a fourth of our society and form part of our family....

"Physical reality, psychic consequences, the processes of deterioration, and the way to relieve them and accompany them on this astonishing journey are a great period of training extending before all of us—researchers and health professionals, family members, the Church, and public institutions....".[6]

5. Pastoral attention. Aging is not just a biological problem. The elderly, in addition to somatic and psychic alterations, must deal with situations of a social nature, especially in a constantly-changing society making them unsure in the face of an uncertain future; consider pensions, the progressive loss of loved ones, etc.—a whole story in which they are no longer main actors and do not feel themselves to be such. It is a story of serenity, relief, leaving aside responsibilities, but also of considerable experience of death, of so many losses leaving an inner void, a kind of tearing away which causes anguish. Reference points are lacking.

Nevertheless, old age is a road to the land of communion and friendship; it is the road of weakness accepted; it is, and must be, a happy age.[7]

This demands a convergence of the responsibilities of the whole social fabric: family, society, and the Church.

The responsibility of the Christian community plays a major role here, for, above all, it enters into a program of credible values.

This responsibility of the Christian community must be manifested in an organization permitting close, practical attention to the elderly. Such programmed attention must be oriented towards the following points.

* Integrating the elderly into parish groups.
* Creating parish centers or clubs for the elderly.
* Creating parish volunteer groups with specific, planned activities: visits, home care, taking the Eucharist by way of the Extraordinary Ministers, etc.
* Plans for the Christian life of the elderly.

As for the final point, it should be recalled that their religious needs reflect the past and their religiosity is linked to already assimilated frameworks. They are sometimes filled with anguish, fears, and uncertainties. Catechesis plays a major role in helping them to introduce order and serenity into their inner lives. Instead of a God inspiring fear, they should be offered a God of love and hope. Catechesis itself will lead to greater participation in the liturgy and sacraments—that is, to travel a road of faith. This religious practice, lived out peacefully in the context of the Christian community, will undoubtedly lead the elderly to feel responsible as apostles in the parish, and everything will appear as a duty and the result of experience. The Pope, in the Exhortation *Christifideles Laici*, so affirms on saying, "The Church asks and expects them to continue their apostolic and missionary activity, not only as possible and proper, even at this age, but rendered to some degree specific and original by this age. It is a task to be taken on by decisively overcoming the temptation to take refuge nostalgically in a past which can no longer return or to flee from present commitment on account of the difficulties encountered in a world with constant novelties, becoming ever more clearly aware of the fact that their role in the Church and society knows no pause at all due to age, but rather encounters only new modalities" (no. 48).

"The main problem in the relation with the elderly is not so much how to move towards them and help them as how to enable them to enter into the very core of our lives, how to create room where they can be received and heard with solicitous attention. But all of this is not easy for us because we also tend to deny the existence not only of the elderly, but of the 'elderly person' who is slowly awakening within us and calls our attention."[8]

I would like to wind up these conclusions with words of thanks and admiration, first of all for so many families who daily remain affectionately at the side of their elderly loved ones.

My thanks and admiration go out to that army of men and women religious who have consecrated their lives to serving the sick, particularly those in the third and fourth age groups. How many gestures of affection, solidarity, and love! How much company in this long solitude!

Finally, a word of thanks and encouragement for all those working in the world of health, that they may continue to apply more and more intelligence, science, and professionalism in the care of the elderly and may always be accompanied by humanity, solidarity, sensitivity, and love.

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Notes

[1] Esempi catechistici «Jesus», n° 53, Ed. dominicana italiana, Napoli, ottobre 1982.

[2] Cfr. Riv. *«Dolentium Hominum»* n° 10/1989. Atti della Terza Conferenza Internazionale *«Longevità e qualità della vita»*. *«Aggiornamenti sociali»* 9-10/1993. *«Situazione degli anziani nella comunità europea»*.

[3] SANDRIN - CARETTA - PETRINI, *«Anziani oggi»* - Ed. Camilliane, Torino 1995, pag. 118; BENCIONILI - VIAFORA *«Etica e Geriatria» (L'anziano cronico non autosufficiente)*, CIC. Ed. Internazionali, Roma 1996.

[4] Cfr. *Dolentium Hominum* n° 10/1989 (Discorso ai Partecipanti alla III Conferenza Internazionale sul tema: *«Longevità e qualità della vita»*.

[5] Cfr. *Dolentium Hominum*, n° 10/1989;

[6] FERNANDO SEBASTIAN *«Atteggiamenti cristiani nei confronti degli anziani malati terminali»* in *Dol. Hom.* n° 29/1995.

[7] JEAN VANIER *«Ogni uomo è una storia sacra»*, EDB, Bologna 1996 (4. *«La vecchiaia: il tempo della serenità e dei lutti»*).

[8] SANDRIN - CARETTA - PETRINI, *«Anziani oggi»*, Ed. Camilliane, Torino 1995, p. 166.

Activities of the Pontifical Council in 1996

In 1996 the Pontifical Council for Pastoral Assistance to Health Care Workers conducted intense and diversified activity in its specific areas of responsibility, seeking to express Christ's compassion and charity towards those suffering in body and in spirit.

At our headquarters the ordinary tasks of correspondence with bishops have continued on questions concerning pastoral care in health, bioethics, and requests for material assistance, as has the work of updating our records, preparing publications, and maintaining personal contact with papal representatives (especially those newly appointed), archbishops, bishops, priests, and men and women religious active in the vast field of health policy and care. Contributions by the Pontifical Council's Members and Consultors have been abundant.

1. Appointments

With letters conveyed through the Secretariat of State, the Holy Father renewed the appointments of the Council's Secretary and Undersecretary for an additional five-year period and named the Members and Consultors (cf. *Dolentium Hominum*, no. 32/1996).

With the Council President's letter of October 26, 1996, Father Krzysztof Jozef Nykiel, a priest from the Archdiocese of Lodz, Poland, was named to the official staff.

2. Celebration of the Fourth World Day of the Sick

The main celebration of the Fourth World Day of the Sick took place in Mexico City, at the National Basilica of Our Lady of Guadalupe. The Pontifical Delegation, headed by the Council's President, Cardinal Fiorenzo Angelini, the Holy Father's *Special Envoy*, included Father José L. Redrado and Father Felice Ruffini, Council Secretary and Undersecretary, respectively; Mr. José Barroso Chávez, President of the Order of Malta in Mexico; and Monsignor Joseph Spiteri, Secretary of the Apostolic Nunciature in Mexico. *Dolentium Hominum* (no. 32/1996) contains broad coverage of this event.

3. Interdepartmental Meetings

a) At the *Pontifical Council for Justice and Peace*, Council Secretary Father José L. Redrado, O.H. took part in a meeting on January 19 on the *World Summit on Social Development* held in Copenhagen under the auspices of the United Nations and on March 26 attended the interdepartmental meeting to prepare *World Peace Day* for 1997.

b) At the *Pontifical Council for the Family*, Father Redrado on July 22 attended the interdepartmental meeting on *certain questions regarding relations between the Holy See and UNICEF*.

c) At the *Pontifical Council Cor Unum*, Father Redrado attended a special meeting on October 19 to prepare 1999 as the Year of Charity, dealing with the theme "The Commitment to Charity: In What Direction?"

d) At the *Pontifical Council for Promoting the Unity of Christians*, Father Jean-Marie Mpendawatu on February 1 attended the interdepartmental meeting of the Roman Curia's Coordinating Commission for Ecumenical Activities.

e) At the *Pontifical Council for Interreligious Dialogue*, on March 26 Father Mpendawatu, an official staff member, took part in the interdepartmental meeting on "Preparing Christians for the Encounter with Moslems."

4. Attendance at Congresses and Conferences

JANUARY

On January 26, Father Felice Ruffini, Council Undersecretary, a member of the Technical Committee for the Great Jubilee of the Year 2000, took part in the meeting held at the Committee's headquarters.

FEBRUARY

On February 3, at Domus Pacis in Rome, Cardinal Fiorenzo Angelini addressed a greeting to the organizational meeting of the National Presidency of the Catholic Union of Italian Pharmacists on "The Role of the Union in the Field of Pharmacy and the Announcement of the Gospel in This Environment."

MARCH

On March 16, at the invitation of the Oasis Association of Our Lady, Cardinal Angelini, accompanied by the Council Secretary, Father Redrado, took part in a conference devoted to the *Charter for Health Care Workers* and spoke on "Procreation and Life." The Council Secretary spoke on "Dying and the Suppression of Life."

APRIL

On April 3, in preparation

for Easter, Cardinal Angelini preached a spiritual retreat for Catholic physicians at LUMSA headquarters in Rome, speaking on "The Easter Duty."

On April 24, Cardinal Angelini presided at the Mass concelebrated at the conclusion of the Congress organized by the Pontifical Council for the Family to mark the First Anniversary of the Encyclical *Evangelium Vitae*.

On April 25, Cardinal Angelini addressed the opening greeting to the meeting of the Executive Council of the Pontifical Academy for Life and of the Academy's Foundation.

On April 28, the Fiftieth Anniversary of Father Damiani's Institute in Pesaro, Italy, Cardinal Angelini presided at a concelebrated Mass at the Pesaro Cathedral, devoting his homily to the exemplary figure of Father Damiani and the great works of charity he performed.

MAY

On May 17, Council Secretary Father Redrado attended the First International Congress in Veroli, Italy of the La Bussola Center for Study and Research in Psychiatry, Psychology, and Human Sciences on "Algos and Pathos in Human Phylogenesis" and spoke on "Our Conflict with Pain and Death: The Search for a Meaning."

May 20-25, official staff member Father Jean-Marie Mpendawatu attended the Forty-Ninth World Assembly of the World Health Organization in Geneva as part of the Delegation of the Holy See.

On May 25, at the Vatican Synod Hall, Cardinal Angelini chaired the closing session of the International Symposium organized by the Pontifical Council for the Interpretation of Legislative Texts, along with the Pontifical Council for the Family and the Pontifical Academy for Life, on "*Evangelium Vitae* and Law."

JUNE

On June 1 and 2, Cardinal Angelini, at the invitation of the Most Rev. C.F. Ruppi, Archbishop of Lecce, Italy, took part in celebrations marking the jubilee of Blessed Filippo Smaldone and presided at a solemn Mass, devoting his homily to the exemplary life of this saint.

On June 5 and 6, Cardinal Angelini, accompanied by Council Secretary Father Redrado, attended the Eighth Congress of the European Federation of Catholic Medical Associations in Prague, the Czech Republic, devoted to "Medicine Today and Our Image of Man." The Cardinal spoke on "Modern Medicine and Our Conception of Man" (cf. *Dolentium Hominum*, no. 33/1996).

June 17-20, in Lubljana, Slovenia, Father Pierluigi Marchesi, O.H., Member of the Council, took part in the Conference of European Health Ministers on "Reforms in European Health Systems" as a member of the Delegation of the Holy See.

JULY

On June 11, Council Secretary Father José L. Redrado, O.H. attended a meeting in Pompei, Italy on "Integrated Networks for Services in Geriatric Care," organized by the Pontifical Sanctuary of Pompei, and presented concluding remarks on "The Youthfulness of Old Age."

OCTOBER

October 6-11, Monsignor Ignacio Carrasco de Paula, Consultor to the Pontifical Council, represented the office at the Fifteenth Latin American Congress on Gynecology and Obstetrics in Asunción, Paraguay and the Eighth Paraguayan Congress on Gynecology and Obstetrics, giving talks entitled, respectively, "Ethical Medicine Is Going Through a Hard Phase" and "The High Rate of Perinatal Mortality in This Country."

October 7-11, in Collevalenza, Italy, Father Redrado presented the *Charter for Health Care Workers* at the National Meeting of the Italian Association for Pastoral Care in Health.

On October 12, in Perugia, Italy, Cardinal Angelini attended the inauguration of the Forty-Fifth National Congress of the Italian Society for Reconstructive and Aesthetic Plastic Surgery and made introductory remarks.

On October 19, in Como, Italy, at the invitation of the Friends of the Organ Association, Cardinal Angelini took part in the award ceremony for the 1996 Albert Schweitzer Prize, presenting this award to Dr. Michel Sabouret, Director of A. Schweitzer Hospital in Lambaréné, Gabon.

DECEMBER

On December 3, at the main auditorium of the University of Catania, Italy, Cardinal Angelini and Father Redrado spoke at a ceremony devoted to the publication *Working to Serve: The Charter for Health Care Workers*, consisting of the proceedings of a meeting held in Troina, Italy in March 1996.

6. Pastoral Visits and Journeys

APRIL

April 19-21, Cardinal Angelini and Father Redrado attended the International Congress on Bioethics in Moscow organized by the Russian Academy of Medical Sciences and presented a paper on *Evangelium Vitae*. While in Moscow, Cardinal Angelini met with a number of civil authorities in connection with the Children's Hospital which the Pontifical Council is building there.

MAY

May 22-24, Cardinal Angelini made a pastoral visit to Gabon, accompanied by Father Felice Ruffini, Undersecretary of the Council; Professor Franco Splendori and Professor Domenico Di Virgilio, Consultors; Father Gianfranco Grieco, journalist on the staff

of *L'Osservatore Romano*; and His Excellency Jean Robert Goulongana, Ambassador of Gabon to Italy. A visit was made to the hospital built in Lambaréné by Dr. Albert Schweitzer and to his room and tomb, with meetings with the Director, health professionals, and patients, along with representatives of the International Association which supports the hospital, nursing sisters, and hospital chaplains. An echograph was donated to the hospital, as well as documentation for the construction of prefabricated houses for the hospital's physicians. Cardinal Angelini also met with many religious and civil leaders.

May 6-10, Cardinal Angelini—accompanied by Father Redrado, Abbot Simone Tonini, O.S.B. Silv., Postulator of the Cause of Beatification of the Servant of God Abbot I. Gregori, and Mother Maurizia Biancucci, Superior General of the Benedictine Congregation of Sisters for Reparation to the Holy Face of Jesus—visited Clifton in the United States and presided at the solemn Mass celebrated at the Monastery of the Holy Face, devoting his homily to the exemplary life of the Servant of God Abbot Ildebrando Gregori and blessing the bust of the Servant of God.

6. Eleventh International Conference

The Eleventh International Conference of the Pontifical Council for Pastoral Assistance to Health Care Workers—bearing the title "In the Image and Likeness of God: Always? Disturbances of the Human Mind"—was held in Paul VI Hall at the Vatican, November 28-30, 1996.

7500 people attended, coming from 105 countries and including six ministers of health, fourteen ambassadors, and two thousand doctors.

Among the sixty-six distinguished speakers were the wife of the President of Portugal, two cardinals, five ambassadors, and numerous expert researchers, scientists, and scholars in the fields of biomedicine, psychology, psychiatry, philosophy, ethics, sociology, law, and moral and pastoral theology. Worthy of special note is the opening address by Cardinal J. Ratzinger, who presented a masterful exposition on the human mind in the light of theology; Nobel Prize winner Erwin Neher spoke on the functioning of cerebral nervous system. The topics dealt with by the Conference included the *structure* of the human mind, data on the incidence of mental disorders, their direct and indirect *causes*, and the *places* where disturbances arise, in addition to the *means of prevention, treatment, and rehabilitation*. There was careful consideration, from an ethical and spiritual standpoint, of the *tasks and methods for care* of the mentally disturbed, in both strictly medical and pastoral terms. Every Conference session included a sampling of music therapy, with the performance of a series of selections by the Symphony Orchestra directed by Professor Adolfo Petiziol, President of the Italian Society for Music Therapy. Works by Wolfgang Amadeus Mozart, Franz Schubert, Ludwig von Beethoven, Gioacchino Rossini, and Helmut Laberer were performed. The Holy Father delivered th closing address.

7. Publications

The journal *Dolentium Hominum. Church and Health in the World*, published three times yearly as the official organ of the Council, appeared regularly in English, Spanish, French, and Italian editions and was well received by health professionals around the world. The first issue to appear each year contains the *Proceedings* of the prior International Conference organized by the Council.

The first edition of *The Charter for Health Care Workers* came out in Italian in October 1994 at the initiative of the Council. *The Charter* has since met with acclaim and is now available in English, Spanish, French, German, Dutch, Polish, Portuguese, Russian, Arabic, Czech, and Romanian, and translations are being prepared in Lithuanian, Madagascan, Albanian, and Hungarian.

8. Other Activities

On November 11, at the Urbanianum Pontifical University, the Second Spirituality Encounter organized by the Benedictine Sisters for Reparation to the Holy Face of Jesus was held, devoted to the Servant of God Abbot Ildebrando Gregori, O.S.B.Silv. and to devotion to the Holy Face of Jesus. Cardinal Angelini spoke on "The Servant of God Abbot Ildebrando Gregori and Our Time," and Father José L. Redrado dealt with "The Mysterious Power of Suffering for a New Evangelization."

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