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Fax: 6988-3139. E-MAIL: opersanit@hlthwork.va

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Message of the Holy Father for The Sixth World Day of the Sick February 11, 1998

Dear Brothers and Sisters!

1. The celebration of the next *World Day of the Sick*, on February 11, 1998, will take place at the Sanctuary of Loreto. The place chosen, recalling the moment when the Word became flesh in the womb of the Virgin Mary by the work of the Holy Spirit, invites us to set our gaze upon the mystery of the Incarnation.

On my repeated pilgrimages to this "first Sanctuary of an international scope dedicated to the Virgin and, for a number of centuries, the true Marian heart of Christendom" (*Letter to the Most Rev. Pasquale Macchi*, Pontifical Delegate for the Sanctuary of Loreto, August 15, 1993), I have always felt the special closeness of the sick who come here trustfully in great numbers. "Moreover, where could they be better received, if not in the house of Her whom the 'Loreto litanies' themselves bring us to invoke as the 'health of the sick' and the 'consoler of the afflicted'?" (*Ibid*.)

The choice of Loreto, therefore, harmonizes well with the long tradition of the Church's loving attention to those suffering in body and in spirit. It will not fail to enliven the prayer which the faithful, trusting in Mary's intercession, offer up to the Lord for the sick. This important occasion also gives the Church community the opportunity to pause in devout recollection before the Holy House, the *icon* of such a basic event and mystery as is the Incarnation of the Word, to receive the light and strength of the Spirit, who transforms man's heart into a *dwelling of hope*.

2. "*And the Word became flesh*" (*Jn* 1:14). In the Sanctuary of Loreto, more than elsewhere, it is possible to sense the profound meaning of these words of John the Evangelist. Within the walls of the Holy House, in an especially forceful manner Jesus Christ, "God with us," speaks to us of the Father's love (cf. *Jn* 3:16), which in the redemptive Incarnation was manifested in the loftiest way. God Himself, in search of man, became man, building a bridge between divine transcendence and the human condition. "Though divine in nature, he did not regard his equality with God as a treasure to be grasped, but stripped himself..., becoming obedient unto death, and death on a cross" (*Ph* 2:6-8). Christ did not come to remove our afflictions, but to share in them and, in taking them on, to confer upon them a salvific value: by becoming a partaker in the human condition, with its limits and its sorrows, He redeemed it. The salvation accomplished by Him, already prefigured in the healings of the sick, opens up *horizons of hope* for all who find themselves in the difficult time of suffering.

3. "*By the work of the Holy Spirit.*" The mystery of the Incarnation is the work of the Spirit, who in the Trinity is "the love-Person, the uncreated gift..., the eternal source of every favor proceeding from God in the order of creation, the direct principle and, in a certain sense, the subject of God's self-communication in the order of grace" (Encyclical *Dominum et Vivificantem*, 50). 1998 is dedicated to Him, the second year of immediate preparation for the Jubilee of the Year 2000.

Poured forth into our hearts, the Holy Spirit brings us to perceive ineffably the "nearby God" revealed to us by Christ: "And your being children is proven by the fact that God has sent into our hearts the Spirit of his Son, who cries out, 'Abba,

Father'" (*Ga* 4:6). He is the true *guardian of the hope* of all human creatures, and especially of those who "possess the first fruits of the Spirit" and "await the redemption of their bodies" (cf. *Rm* 8:23). In man's heart the Holy Spirit, as the liturgical Sequence for the Solemnity of Pentecost proclaims, becomes the true "father of the poor, giver of gifts," and "light of hearts"; He becomes the "sweet guest of the soul" who brings "repose" in weariness, "shelter" in the "heat" of the day, and "comfort" in the midst of the preoccupations, struggles, and dangers in every period. It is the Spirit who gives the human heart the strength to face difficult situations and overcome them.

4. "*In the womb of the Virgin Mary*." When we contemplate the walls of the Holy House, we seem to be hearing still the echo of the words with which the Mother of the Lord gave her assent and her cooperation to God's salvific project: *ecce*, generous abandonment; *fiat*, trusting submission. Having become *pure capacity for God*, Mary made her life constant cooperation with the saving work carried out by her Son, Jesus.

In this second year of preparation for the Jubilee, Mary must be contemplated and imitated "above all, as the woman docile to the voice of the Spirit, the woman of silence and listening, the *woman of hope*, who, like Abraham, was able to accept God's will, 'hoping against all hope' (*Rm* 4:18)" (Apostolic Exhortation *Tertio Millennio Adveniente*, 48). On declaring Herself to be the *servant of the Lord*, Mary knew She was also placing Herself at the service of his love for men. By her example, She helps us to understand that the unconditional acceptance of God's sovereignty places man in an attitude of complete openness. In this way, the Virgin becomes the icon of watchful attention and compassion towards those suffering. Significantly, after having generously listened to the Angel's message, She went in haste to serve Elizabeth. Later on, in the embarrassing situation of the spouses at Cana She would grasp the appeal to intervene to assist them, thus becoming an eloquent reflection of God's provident love. The Virgin's *service* was manifested to a maximum degree in her sharing in the suffering and death of her Son when, at the foot of the cross, She accepted her mission as Mother of the Church.

In looking at Her, the *Health of the Sick*, many Christians over the course of the centuries have learned to robe their care of the sick in maternal tenderness.

5. The contemplation of the mystery of the Incarnation, evoked with such immediacy by the House in Loreto, enlivens faith in the saving work of God, who in Christ has freed man from sin and death and opened his heart to hope in the new heavens and the new earth (cf. *2 P* 3:13). In a world lacerated by sufferings, contradictions, selfishness, and violence, the believer lives in the awareness that "all creation moans and suffers until the present in birth pangs" (*Rm* 8:22) and takes on the commitment to be a witness to the Risen Christ in word and deed.

For this reason, in the Apostolic Exhortation *Tertio Millennio Adveniente*, I invited believers to value "the signs of hope present at the close of this century, in spite of the shadows often concealing them from our sight," and to reserve special attention for the "progress made by science, technology, and, above all, medicine in service to human life" (no. 46). The successes achieved in overcoming diseases and relieving sufferings must not, however, lead us to forget the numerous situations in which the centrality and dignity of the human person are ignored and trampled upon, as occurs when health care is regarded in terms of profit and not as generous service, when the family is left alone in the face of health problems, or when the weakest groups in society are forced to endure the consequences of unjust neglect and discrimination.

On the occasion of this *World Day of the Sick*, I wish to exhort the Church community to renew its commitment to transforming human society into a "*house of hope*," in collaboration with all believers and man of good will.

6. This commitment requires that the *Church community* live out communion: only where men and women, through listening to the Word, prayer, and celebration of the sacraments, become "one single heart and one single soul" do fraternal solidarity and the sharing of goods grow, and what St. Paul reminds the Christians in Corinth of becomes a reality: "If one member suffers, all the members suffer together" (*1 Co* 12:26).

As she prepares for the Great Jubilee of the Year 2000, the Church is called to intensify her efforts to translate the communion suggested by the Apostle's words into concrete projects. Dioceses, parishes, and all communities in the Church should devote themselves to presenting the subjects of health and illness in the light of the Gospel; encourage the advancement and defense of life and the dignity of the human person, from conception until natural death; and make the preferential option for the poor and the marginalized concrete and visible—as regards the latter, the victims of the new social maladies, the disabled, the chronically ill, the dying, and those who are forced by political and social disorder to leave their land and live in precarious or even inhuman conditions should be surrounded with loving attention.

Communities able to live out an authentic Gospel *diakonia* by seeing "their Lord and Master" in the poor and the sick constitute a bold announcement of the resurrection and contribute to effectively renewing hope "in the definitive coming of the Kingdom of God."

7. Dear *people who are ill*, a special place is reserved for you in the Church community. The condition of suffering in which you live and the wish to recover health make you particularly sensitive to the value of hope. To the intercession of Mary I entrust your aspiration to bodily and spiritual well-being, and I exhort you to enlighten and elevate it with the theological virtue of *hope*, a gift of Christ.

It will help you to give a new meaning to suffering, transforming it into a *way of salvation*, an occasion for evangelization and redemption. Indeed, "suffering can also have a positive meaning for man and for society itself, called as it is to become a form of sharing in the salvific suffering of Christ and in his joy as the risen one and, therefore, a power for sanctification and the upbuilding of the Church" (*Christifideles Laici*, 54; cf. Encyclical *Salvifici Doloris*, 23). Your experience of pain, modeled on Christ's and indwelt by the Holy Spirit, will proclaim the victorious power of the Resurrection.

8. The contemplation of the Holy House naturally leads us to dwell upon the *Family of Nazareth*, where trials were not lacking: in a liturgical hymn it is described as "experienced in suffering" (*Roman Breviary*, Office of Readings for the Solemnity of the Holy Family). That "holy and sweet dwelling" (*ibid*.) was, however, also rendered joyful by the most transparent joy.

My wish is that from that home the gift of serenity and trust may reach every human family wounded by suffering. While inviting the ecclesiastical and civil community to assume responsibility for the difficult situations in which many families find themselves, under the burden imposed by the illness of a relative, I remind you that the Lord's command to visit the sick is addressed first of all to the relatives of the ill. When carried out in a spirit of loving self-donation and supported by faith, prayer, and the sacraments, the care of sick relatives can be transformed into an irreplaceable therapeutic instrument for the ill and become an occasion for everyone to discover precious human and spiritual values.

9. In this context, my thoughts turn particularly to *health care and pastoral workers*, both professionals and volunteers, who continuously live in proximity to the needs of the sick. I wish to exhort them always to maintain a lofty conception of the task entrusted to them, without letting themselves be overcome by difficulties and incomprehension. To dedicate oneself to the world of health care does not

mean only to combat evil, but, above all, to promote the quality of human life. Moreover, the Christian, in the awareness that "the glory of God is living man," honors God in the human body, both under the captivating aspects of strength, vitality, and beauty and under those of fragility and decline. He always proclaims the transcendent value of the human person, whose dignity remains intact even in the experience of pain, illness, and aging. Thanks to faith in Christ's victory over death, he trustingly awaits the moment when the Lord "will transfigure our mortal body to conform it to his glorious body, by virtue of the power he has to subject all things to himself" (*Ph* 3:21).

Unlike those who "lack hope" (cf. *1 Th* 4:13), the believer knows that the time of suffering represents an occasion for new life, grace, and resurrection. He expresses this certainty through therapeutic dedication, a capacity for accepting and accompanying, and sharing in the life of Christ communicated in prayer and the sacraments. To take care of the sick and dying, to help the *outward man* that is decaying so that the *inward man* may be renewed day by day (cf. *2 Co* 4:16)—is this not to cooperate in that *process of resurrection* which the Lord has introduced into human history with the paschal mystery and which will be fully consummated at the end of time? It this not to account for the hope (cf. *1 P* 3:15) which has been given to us? In every tear which is dried there is already an announcement of the last times, a foretaste of the final plenitude (cf. *Rv* 21:4 and *Is* 25:8).

Aware of this, the Christian community strives to care for the sick and promote the quality of life, cooperating with all men of good will. It performs this delicate mission in service to man, both in respectful, but firm discussion with the forces manifesting different moral views and by a positive contribution to legislation on the environment, support for equitable distribution of health resources, and the promotion of greater solidarity between rich and poor peoples (cf. *Tertio Millennio Adveniente*, 46).

10. To Mary, Consoler of the afflicted, I entrust those who suffer in body and in spirit, together with health workers and all who generously devote themselves to care of the sick.

To You, Virgin of Loreto, we trustfully turn our gaze.

We ask You, "our life, our sweetness, *our hope*," for the grace to be able to await the dawn of the third millennium with the same sentiments which throbbed in your heart as you awaited the birth of your Son, Jesus.

May your protection free us from pessimism, causing us to glimpse, in the midst of the shadows of our time, the luminous traces of the Lord's presence.

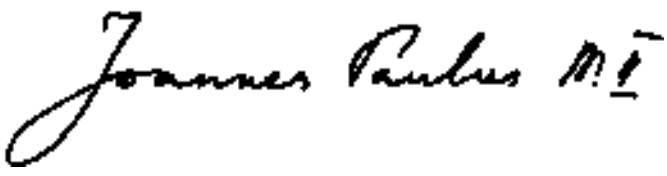
To your tenderness as a mother we entrust the tears, sighs, and hopes of the sick. May the balm of consolation and hope beneficently descend upon their wounds. May their pain, united to Jesus', be transformed into an instrument of redemption.

May your example lead us to turn our existence into continuous praise of God's love. Make us attentive to the needs of others, solicitous in bringing aid to those suffering, and capable of accompanying those who are alone, and make us builders of hope where man's dramas are being consummated.

At every stage of our way, with a mother's affection show us "your Son, Jesus, O clement, O loving, O sweet Virgin Mary."

Amen.

From the Vatican, June 29, 1997,
Solemnity of the Holy Apostles Peter and Paul.



Presentation of the Message at the Vatican Press Center

The Holy Father's Message for the Sixth World Day of the Sick was presented on the morning of July 3 to the journalists gathering in John Paul II Hall at the Vatican Press Center. The press conference was chaired by Archbishop Javier Lozano, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, and among those present were Archbishop Angelo Comastri, Pontifical Delegate for the Loreto Sanctuary; Rev. José L. Redrado, Secretary of the Pontifical Council; Rev. Felice Ruffini, Council Undersecretary; Monsignor Sergio Pintor, National Director for the Health Ministry of the Italian Bishops' Conference; and Rev. Angelo Brusco, Superior General of the Camillians.
We include the remarks by Archbishop Lozano and Archbishop Comastri.

A Message Looking Towards the Jubilee

The Pope's Message is a profound one and is oriented towards Jubilee preparations in 1998, the year devoted to the Holy Spirit, in the light of the virtue of hope.

The address begins with a reference to the Sanctuary of Loreto, an icon of the Incarnation and the place where the Pope felt very close to the sick. He then observes, "The Word became flesh by the work of the Holy Spirit in the womb of the Virgin Mary." The Incarnation of the Word is seen as the horizon of the hope to be reached to free us from our sufferings—it is a sign of the Father's love. The Holy Spirit is viewed as the guardian of hope who gives man's heart the strength to face and overcome difficult moments; and Mary, the woman of hope, the only one fully united to God, the servant of the Lord, is contemplated as the woman who, aware of God's sovereignty, has placed herself at the service of men to heal the sick.

The Incarnation of the Lord has freed us from sin and death, but, in the face of signs of hope, in the field of medicine, too, we often live through situations in conflict with human dignity. It is for this reason that the Pope in Loreto exhorts us to transform society into a house of hope so that the Church community will live out communion by fraternal solidarity and the sharing of goods at different levels, so as to recognize its Lord and Master in the sick.

The Pope goes on to invite the sick to be sensitive to the virtue of hope, affirming the mysterious power of the Resurrection in their own suffering. Families, following the example of the family in Nazareth, must take care of their own sick; health professionals and volunteers must promote the quality of life and honor God in the human body, cooperating with the Resurrection event and accounting for hope by way of their action.

The Pope concludes by invoking Mary, the consoler of the afflicted, and entrusts those who suffer to Her. She is our hope, and in order for her protection to free us from pessimism, we entrust to Her the tears, sufferings, and hopes of the sick and ask Her to make our existence a continual praise of God's love. And we, the builders of hope, entrust ourselves to Her so that in every glorious or sad stage on our way She may show us her Son Jesus Christ, with the affection of a mother.

+ JAVIER LOZANO BARRAGÁN
President of the Pontifical Council
for Pastoral Assistance to Health Care Workers

Loreto, the House of the Mother

I wish to convey my profound and heartfelt thanks to the Holy Father for having chosen the Sanctuary of Loreto for the celebration of the Sixth World Day of the Sick.

The words with which the Holy Father justifies this choice are touching.

On my repeated pilgrimages to this "first Sanctuary on an international scale devoted to Our Lady and for many centuries the true Marian heart of Christianity" (Letter to Monsignor Pasquale Macchi, August 15, 1993), I have always felt the special closeness of the sick, who come here with trust and confidence in great numbers. "Moreover, where could they be better received than in the house of Her whom the Loreto litanies themselves have us invoke as the 'health of the sick' and 'consoler of the afflicted'?" (Message for the Sixth World Day of the Sick).

Loreto is the Sanctuary of the House of the Mother, and the House of the Mother is the place where all the children feel attracted, welcomed, understood, loved, and comforted.

For this reason, since its origins the Loreto Sanctuary has exercised an extraordinary fascination.

The list of pilgrims is endless: Popes (the first was Nicholas V in 1449, and the last, John Paul II); kings and emperors; artists (such as Michelangelo Buonarroti, Wolfgang Amadeus Mozart, and Pietro Mascagni); poets and writers (such as Torquato Tasso, Vittorio Alfieri, and Carlo Goldoni); journalists (Louis Veulliot); scientists (Galileo Galilei was a pilgrim in 1618 and 1633, and Enrico Medi, in 1966); and simple members of the faithful who have gone up the hill of Loreto to breathe in Mary's "yes." But the Loreto Sanctuary has been frequented by the saints, in particular: St. Francis of Paola in 1430, St. James della Marca in 1463, St. Ignatius of Loyola in 1523, St. Francis Xavier in 1538 and 1540, St. Peter Canisius in 1558, and St. Charles Borromeo in 1566, 1572, 1579, and 1583 (traveling on foot for long stretches of the route). St. Camillus de Lellis, the tireless apostle of the suffering, came in 1567, 1570, and on other occasions; St. Louis Gonzaga, in 1585; St. Francis de Sales, the protector of journalists, in 1599; St. Joseph Benedict Labre, in 1770 and many other times; St. Paul of the Cross, in 1739; St. Leonard of Porto Maurizio, in 1747; St. Thérèse of Lisieux, in 1887 (she fondly recalled her pilgrimage to Loreto); Charles de Foucauld, in 1900; St. Leopold Mandic and St. Maximilian Kolbe, in 1919—on down to St. Frances Cabrini, Blessed Father Luigi Orione, Blessed Cardinal Ferrari, Blessed José María Escrivá de Balaguer, and the Servant of God Giorgio La Pira, who were all pilgrims in this century.

But "a special place in the history of the Loreto Sanctuary has been occupied by the sick, who were the first to go as pilgrims to the Holy House and give it renown among people. Today as well their presence, especially in the 'White Train,' is what brings the Sanctuary certain moments pulsing with faith and intense devotion" (John Paul II's Letter to the Most Rev. Pasquale Macchi, August 15, 1993).

Each year the "White Trains" visit Loreto from all the regions of Italy and the Republic of San Marino, too; on the average, there are forty-five trains a year.

The Pope further wrote, "In Loreto people are touched by Mary's faith" (ibid.) and go back home comforted by a mother's presence and embrace in which there is observed the very tenderness of God, who in Mary's womb took on human flesh so as to be Emmanuel—that is, God-with-us.

The "trains of joy and grace" also come to Loreto each year. These are pilgrimages of

children marked by pain who in Loreto experience touching days of serene happiness, intense prayer, and authentic brotherhood in the company of their families.

We are now looking towards The Sixth World Day of the Sick, which is being celebrated in the second year of preparation for the Great Jubilee of the Year 2000, in the year of the Holy Spirit, in collaboration with the Pontifical Council for Pastoral Assistance to Health Care Workers and the Office for the Healthcare Ministry of the Italian Bishops' Conference. Loreto is opening up its mind and heart, facilities and personnel, so that there may be written a new page of attention, receptiveness, and dedication to our suffering brothers and sisters, in whom we recognize a mysterious, but true presence of Jesus Christ.

In the society of unbridled consumption those who suffer threaten to become just an uncomfortable weight, whereas they are a goad for selfishness and an invitation to build human society on the foundation of self-giving; it is, indeed, in self-giving that "man finds the fulfillment of his own destiny" (TMA, 9).

May the Holy Spirit, Love Incarnate, pervade us with Love so that we may all emerge from the sadness of selfishness and savor the very joy of God, which is the joy of self-giving.

+ ANGELO COMASTRI
Archbishop of Loreto

The Healthcare Ministry in the Postsynodal Apostolic Exhortation *A New Hope for Lebanon*

At the end of the Exhortation *A New Hope for Lebanon* John Paul II invites the Secretariat of State and the different offices of the Holy See to place themselves at the service of the Church in Lebanon (no. 124). Our office, the Pontifical Council for Pastoral Assistance to Health Care Workers, takes this occasion to place itself at the service of the Church in Lebanon and cooperate as far as possible for the good of the pilgrim Church there.

It is a Church which has suffered greatly of late, with the recent scars of a brutal civil war still continuing in high-risk areas marked by full-scale conflict.

The subjects of suffering and health, of the sick and health professionals, had to be present in this exhortation, in the face of their lacerating impact.

The Church and the Kingdom of God consist of the divinization of man, as we are told by the Apostolic Exhortation, which reflects the profound theology of the Eastern Church; and we approach divinization by following in the footsteps of the suffering Christ to arrive at maximum communion, which is the essence of the Church issuing from the depth of Trinitarian communion.

If we concentrate on what directly concerns our topic—the health ministry—we find some explicit references in the Exhortation.

1. Suffering and Pain

In no. 34 (Chapter I, Section 2, on hope rooted in Christ), the Pope deals with the problem of suffering in an original way. In addition to what he has stated elsewhere, especially in *Salvifici Doloris*, about taking on pain in Christ, the Pope affirms that "the cross of suffering includes inevitable pains in men's lives, but, for the believer, it also includes the suffering of being oneself an obstacle to Christ's love, a disfigured reflection of his face"; and it is "the tension characteristic of sinful creatures": on the one hand, good is sought after; on the other, however, people get carried away by evil. It is the realism of life in conflict. Good and evil intersect, and this presence of evil saddens us and causes us pain. It is the pain of harming other persons, and one must try to remove it.

One of the outstanding ideas in the Exhortation is the conception of the Church as communion; the evil of conflict and division is the evil we must always flee from, for it is most destructive to this communion. It is a pain which must be avoided and combatted by obediently following "the law of Christ (Ga 6:2), that of the Beatitudes, and that of charity which knows no limit."

2. Visiting the Sick

No. 65 (Chapter III, Section 3, on the structures of communion) refers to the "pastor, who must take care of the whole flock without neglecting the weakest members..., those who, in undergoing sickness, need to be visited at home...." "I cordially exhort the pastors," the Pope says, "to visit the faithful who have been entrusted to them so as to be at their side, thereby reinforcing the bonds among all the members of the parish community, in order to accompany them in their spiritual lives and sustain them in their trials."

Everywhere there is an effort to shorten stays in all kinds of health facilities and to provide a good deal of home care. In addition, since it is impossible for many of the sick to be hospitalized, they remain at home and seek to be cured there with the means available.

All of this entails an exercise of the health ministry which must be increasingly joined to parishes and their pastors; assistance, accompaniment, and the sacraments must be provided more at home than at health facilities. Volunteers must also move in that direction and commit themselves, together with pastors and the parish ministry, to caring for the sick.

3. The Organization of Health Care

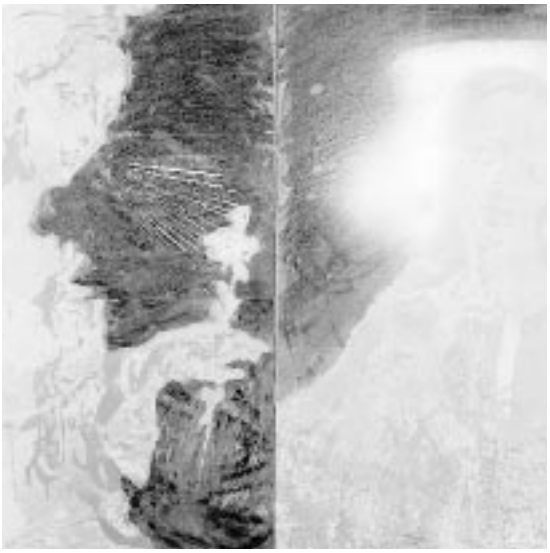
In no. 102 (Chapter VI, entitled "The Church's Service to Society," Section 1), there is reference to the problems resulting from war; it is the point in the Exhortation where there is most attention to health.

There is discussion of the way war has made an impact on the health field and of the need for solidarity in this field so that "all persons may benefit from needed medical care and assistance, regardless of their resources." In this area the Church must reflect to see what she can do. This involves pastoral action to accompany the needy sick during illness.

It also means that the Church must seriously conduct an in-depth study on the organization of health services and her institutions. In this way the Church will bear witness increasingly to her love for men. To do so, she must make her health facilities accessible to the poorest. It is an action for which everyone is responsible. It will be coordinated by the Patriarchs, but all those responsible for Catholic facilities—men and women religious and lay people—are involved (no. 103).

The Pope is here proposing wide-ranging action for Lebanon. Planning in which the whole Church is an active subject and the sick—especially the poorest and neediest—are the objective is required for determining action. Organization, study, and an effort towards unification and fostering effectiveness are needed. Such action is urgent, for it is a matter of staving off immediate war. This involves a whole ministry of communion so that the Church will be credible in attending to her weakest members. It is the other side of Christ's own action in caring for the sick and announcing the Gospel. We are faced with the deepest exigencies of the Church's social service, with a preferential option for the poorest and neediest.

The renewal of the Church is moving along the pathways of communion in accompanying the sick and stimulating health care, which involves not only physical aspects, not only removing affliction and pain, but also mental, social, and spiritual aspects. It is a question of returning to the harmony of communion along the Paschal route of death and resurrection in Christ, so as to reproduce the original harmony of the Most Holy Trinity in man.



Remarks to the Synod on America[1]

THE HEALTHCARE MINISTRY

For over five hundred years the Church in America has encountered Jesus Christ in person through the health apostolate, in its ongoing work in this field. Innumerable Catholic health facilities have arisen throughout the hemisphere, under the auspices of dioceses or religious congregations and also run by the laity.

It is now necessary for our America to be converted to Jesus Christ with a new awareness so as to encounter Him in the culture of life, combatting the culture of death, which is present in so many problems around us. This Synod must make us aware of the effectiveness of the single Catholic Church in the hemisphere, whose unity demands full equality among our particular churches and their convergence in mutual ecclesial service, with all giving to and receiving from all, in complete communion. Specifically, in terms of the health apostolate, we need to enter into communion with Jesus Christ by means of communion with the world of health care, particularly with our suffering brothers and sisters in the different countries of our America, creating new solidarity in our hemisphere. The Pontifical Council for Pastoral Assistance to Health Care Workers proposes the following suggestions for implementing this apostolate.

1. The healthcare ministry should form an effective part of ordinary planning in each Diocese and in the Bishops' Conferences.

2. The Bishops' Conferences should foster the union of Catholic hospitals, chaplains, doctors, nurses, and pharmacists nationally and internationally.

3. Priority should be given to the fight against smoking, alcoholism, drug addiction, and AIDS, which are among the main factors in adult mortality today.

4. Each Diocese should make a commitment to advancing the culture of life over against the culture of death, with specific programs focusing on the preferential option for the poor and respect for nascent life.

5. We Pastors should be aware of the need for a specific ministry to the elderly and for a moral approach to palliative care.

6. The best-endowed Catholic hospitals in the hemisphere should create hospitals in needy regions in America to provide care for the marginalized.

7. The Catholic hospitals of America should take the Christian sharing of goods as the starting point for economic questions so that profit will not be their aim, but the Christian vision of health, life, illness, and death.

8. Parish priests throughout the hemisphere should give priority to the full scope of the health apostolate.

9. Seminaries in the hemisphere should teach the pastoral theology of health care in particular, placing stress on the current bioethical problems posed by genetic engineering.

+ JAVIER LOZANO BARRAGAN
President of the Pontifical Council for Pastoral Assistance to Health Care Workers

[1] To avoid confusion for English-speaking readers, we specify that the term "America" has been used—as is common in the Spanish language, for example—to refer to the whole Western Hemisphere. Precisely the unity of the Hemisphere was among the key points proposed by the Holy Father for the consideration of the Synod.

Magisterium

Addresses
by the Holy Father

Mother Teresa of Calcutta: A Clear Example for All

THE POPE'S WORDS AT THE ANGELUS ON SUNDAY, SEPTEMBER 7, 1997

1. At this time of prayer I am pleased to recall our very dear sister, *Mother Teresa* of Calcutta, who two days ago ended her long earthly journey. I had the opportunity to meet her many times and I have a vivid memory of her diminutive figure, bent over by a life spent in service to the poorest of the poor, but always filled with inexhaustible interior energy: the energy of Christ's love.

Missionary of Charity: this is what Mother Teresa was in name and in fact, offering such an appealing example that she attracted to herself many people who were ready to leave everything to follow Christ present in the poor.

Missionary of Charity. Her mission began every day, before dawn, in the presence of the Eucharist. In the silence of contemplation, Mother Teresa of Calcutta heard the echo of Jesus' cry on the cross: "I thirst." This cry, received in the depths of her heart, spurred her to seek out Jesus in the poor, the abandoned and the dying on the streets of Calcutta and to all the ends of the earth.

2. Dear brothers and sisters, this sister, universally known as the Mother of the poor, leaves *an eloquent example for everyone,* believer and nonbeliever. She leaves us the witness of God's love, which she accepted and which transformed her life into a total gift to her brothers and sisters. She leaves us the witness of contemplation which becomes love, of love which becomes contemplation. The works she accomplished speak for themselves and show the people of our time that *lofty meaning of life* which unfortunately seems often to be lost.

She loved to say again and again: "To serve the poor in order to serve life." Mother Teresa never missed an opportunity to stress in every way *love for life.* She knew by experience that life acquires all its value, even amid difficulties and contradictions, when it encounters love. And by following the Gospel, she became a "good Samaritan" to everyone she met, to every life in crisis, suffering and scorned.

3. In Mother Teresa's great heart a special place was reserved for *the family.* "A family that prays," she said at the first World Meeting of Families, "is a happy family." Today the words of this unforgettable *Mother of the poor* are as powerful as ever.

"In the family we are loved as God loves: it is a love of sharing. In the family one experiences the joy of loving and being loved by one another. In the family one must learn to pray together. The fruit of prayer is faith; the fruit of faith is love; the fruit of love is service; and the fruit of service is peace" (cf. *L'Osservatore Romano,* October 9 1994, p. 4). How could we fail to accept this invitation to base the authentic well-being and true happiness of the family on the solid foundation of prayer, love and mutual service? May these reflections of hers be a useful contribution to the preparation of the Pope's second meeting with families, which will be held in Rio de Janeiro October 2-5, 1997.

As I entrust the generous soul of this humble and faithful religious to the Lord, let us ask the Blessed Virgin to support and comfort the sisters of her community and everyone throughout the world who knew and loved her.

Whoever sincerely says, “Jesus, I trust in you” will find comfort in all his fears.

THE HOLY FATHER ON THE EVENING OF SATURDAY, JUNE 7,1997, VISITED THE SHRINE OF DIVINE MERCY IN KRAKOW, LOCATED IN THE FORMER CONVENT CHAPEL OF THE SISTERS OF THE BLESSED VIRGIN MARY OF MERCY.

1. *“Misericordia Domini in aeternum cantabo”* (Ps 89:1).

Here I have come to this shrine as a pilgrim to take part in the unending hymn in honour of Divine Mercy. The psalmist of the Lord had intoned it, expressing what every generation preserved and will continue to preserve as a most precious fruit of faith. There is nothing that man needs more than Divine Mercy—that *love which is benevolent, which is compassionate, which raises man above his weakness to the infinite heights of the holiness of God.* In this place we become particularly aware of this. From here, in fact, went out the Message of Divine Mercy that Christ himself chose to pass on to our generation through Bl. Faustina. And it is a message that is clear and understandable for everyone. Anyone can come here, look at this picture of the merciful Jesus, his Heart radiating grace, and hear in the depths of his own soul what Bl. Faustina heard: *“Fear nothing. I am with you always”* (*Diary*, q. II). And if this person responds with a sincere heart, *“Jesus, I trust in you!”* he will find comfort in all his anxieties and fears. In this dialogue of abandonment, there is established between man and Christ a special bond that sets love free. And “there is no fear in love, but perfect love casts out fear” (1 Jn 4:18).

The Church rereads the message of mercy in order to bring with greater effectiveness to this generation at the end of the millennium and to future generations *the light of hope*. Unceasingly the Church implores from God mercy for everyone. “At no time and in no historical period—especially at a moment as critical as our own—can the Church forget the prayer that is a cry for the mercy of God amid the many forms of evil which weigh upon humanity and threaten it.... The more the human conscience succumbs to secularization, loses its sense of the very meaning of the word ‘mercy,’ moves away from God and distances itself from the mystery of mercy, the more the Church has the right and the duty to appeal to the God of mercy ‘with loud cries’” (*Dives in misericordia*, no. 15). Precisely for this reason this shrine too has found a place on my pilgrim itinerary. I come here to commend the concerns of the Church and of humanity to the merciful Christ. On the threshold of the third millennium I come to entrust to him once more my Petrine ministry—“Jesus, I trust in you!”

The message of Divine Mercy has always been near and dear to me. It is as if history had inscribed it in the tragic experience of the Second World War. In those difficult years it was *a particular support and an inexhaustible source of hope*, not only for the people of Kraków but for the entire nation. This was also my personal experience, which I took with me to the See of Peter and which in a sense forms the image of this Pontificate. I give thanks to divine Providence that I have been enabled to contribute personally to the fulfilment of Christ’s will, through the institution of the Feast of Divine Mercy. Here, near the relics of Bl. Faustina Kowalska, I give thanks also for the gift of her beatification. I pray unceasingly that God will have “mercy on us and the whole world” (*Chaplet*).

2. “Blessed are the merciful, for they shall obtain mercy” (Mt 5:7).

Dear Sisters! An extraordinary vocation is yours. Choosing from among you Bl. Faustina, Christ has made your congregation the guardian of this place, and at the same time he has called you to a particular apostolate, that of his mercy. I ask you: accept this responsibility! The people of today need your *proclamation of mercy*; they need your *works of mercy*; they need your *works of mercy* and they need your *prayer to obtain mercy*. Do not neglect any of these dimensions of the apostolate. Fulfil it in union with the Archbishop of Kraków, to whose heart is so dear the devotion to the Divine Mercy, and in union with the whole ecclesial community over which he presides. May this shared work bear much fruit! May the Divine Mercy transform people’s hearts! May this shrine, known already in many parts of the world, become a centre of worship of the Divine Mercy which shines on the whole Church!

Once more I ask you to pray for the intentions of the Church and to support me in my *ministerium Petrinum*. I know that such prayer is always offered here: I thank you for this with all my heart. We all need it so much: *tertio millennio adveniente*.

I cordially bless all who are present here and all those devoted to the Divine Mercy.

I Salute All Health-Care Workers Who Put God’s Law Above What Human Law Allows

EARLY ON MONDAY MORNING, JUNE 9, 1997, THE HOLY FATHER VISITED THE NEW HEART SURGERY CLINIC OF JOHN PAUL II HOSPITAL IN KRAKOW.

Dear Friends,

1. I am very pleased that during this pilgrimage to my native land I am able to visit the specialized hospital in Kraków and bless the newly built Cardiology Clinic. I am pleased to meet on this occasion the sick and those who take care of them. I am moved as I come among you and I thank the administration and staff for having invited me.

In 1913, the Kraków City Council had decided to build on this very spot, at Bialy Prądnik, the Municipal Institutes of Health. Construction was completed four years later. This year the hospital is celebrating the 80th anniversary of its existence and its generous service to the sick. How can we fail to remember on this occasion all those who, putting their own health at risk, gave themselves to the task of bringing help, like good Samaritans, to the suffering? We bow our heads, thinking especially of those who paid the supreme price and offered their lives. Some of us certainly remember Dr. Aleksander Wielgus, who died in 1939 after contracting tuberculosis, or Dr. Sielecka-Meier, who died of the same cause soon after the liberation. How can we fail to remember also the work of the Sisters of the Sacred Heart, so filled with dedication to the Gospel? By their service to the sick, sacrificing their own health and sometimes even their lives, they wrote a beautiful page in the history of this hospital. On two occasions Bl. Sr Faustina was treated here.

This specialized hospital has now been made even better by the addition of a new cardiology clinic. I wish to express my sincere appreciation to those who have helped to build it. Many people contributed, and it would be difficult to name all of them here. We thank God today for the gift of human work and human solidarity with the sick.

I appreciate all who defend God’s law about human life

2. “As you did it to one of the least of these my brethren, you did it to me” (Mt 25:40). With these words of Christ I address you who work in this hospital and, through you, all health-care workers in Poland. My consideration and respect for your service is great. It demands a spirit of sacrifice and dedication to the sick, and therefore has a profoundly

evangelical dimension. From the viewpoint of faith your service is seen as directed to Christ himself, mysteriously present in those tried by suffering. For this reason your profession deserves the greatest respect. It is a mission of extraordinary value, the best definition of which is found in the word *vocation.*

I am well aware of the extremely difficult conditions in which you sometimes have to work. I am confident that in Poland all the problems of health-care services will be solved, in a wise and fair manner, for the good of the patients and those who take care of them.

Accept today the expression of my appreciation for this generous work undertaken with self-sacrifice. In a certain sense, you take on your own shoulders the weight of the suffering and pain of your sisters and brothers, by trying to give them relief and to restore the health for which they yearn. My appreciation goes in a special way to all who courageously remain on the side of the divine law which guides human life. I repeat once more what I wrote in my Encyclical *Evangelium Vitae:* "Your profession calls for you to be guardians and servants of human life. In today's cultural and social context, in which science and the practice of medicine risk losing sight of their inherent ethical dimension, you can be strongly tempted at times to become manipulators of life, or even agents of death. In the face of this temptation your responsibility today is greatly increased. Its deepest inspiration and strongest support lie in the intrinsic and undeniable ethical dimension of the health-care profession, something already recognized by the ancient and still relevant Hippocratic Oath, which requires every doctor to commit himself to absolute respect for human life and its sacredness" (cf. no. 89).

I rejoice that the medical world in Poland, in the vast majority of cases, accepts this responsibility, not only by caring for and sustaining life but also by firmly avoiding actions that would lead to its destruction. With my whole heart I praise the doctors, nurses and all Polish health-care workers who place the divine law "Thou shalt not kill" above what human law allows. I praise you for this witness that you are giving, especially recently.

Place your pain
at the foot of Christ's Cross

I ask you to continue with perseverance and enthusiasm your praiseworthly duty of serving life in all its dimensions, according to your particular specializations. My prayer will sustain you in this service.

3. To you, dear friends who are sick and who are taking part in this meeting, and to those who cannot be present with us here, I extend a cordial greeting. Every day I try to be close to your sufferings. I can say this because I am familiar with the experience of a hospital bed. Precisely because of this, with greater insistence in my daily prayer I beseech God for you, asking him to give you strength and health; I pray that in your suffering and sickness you will not lose hope; I pray that you will be able to place your pain at the foot of Christ's Cross. From a human point of view the situation of a sick person is difficult, painful and sometimes even humiliating. But is is precisely because of this that you are in a special way close to Christ, and in a certain sense share physically in his sacrifice. Try to remember this. The Passion and Resurrection of our Saviour will help you grasp the mystery of your suffering.

I must admit that during the 58 years I lived in Poland I had few hospital experiences. Only as a boy, because my elder brother was a doctor, and then because of the accident I had towards the end of the war. And that was all. I have had many more experiences in Rome. I have visited the Gemelli Polyclinic at least four times, either for a few days or for a few weeks. Dr Buzzonetti, who has accompanied me on this journey, can testify to this.

It is thanks to you, thanks to your communion with the Crucified One, that the Church possesses inestimable wealth in her spiritual treasury. Thanks to you, others can draw from this treasury. Nothing enriches others like the free gift of suffering. Therefore always remember, especially when you feel abandoned, that the Church, the world, our homeland need you so much. Remember also that the Pope needs you.

In closing, I wish to say to all of you that I have greatly looked forward to this meeting. It could not have been left out of my pilgrim itinerary. I pray that the power of faith will support you in these difficult moments of your lives, moments filled with torment. I pray that the light of the Holy Spirit will help you to discover that suffering ennobled by love "is something good, before which the Church bows down in reverence with all the depth of her faith in the Redemption" (*Salvifici Doloris*, no. 24). Commending to God all the sick and those who take care of them, I cordially bless you all.

The Family Is an Irreplaceable Community of Love

THE HOLY FATHER SPOKE FRIDAY, JUNE 13, 1997, TO THOSE ATTENDING AN INTERNATIONAL MEETING ORGANIZED BY THE PONTIFICAL COUNCIL FOR THE FAMILY ON THE THEME: "FAMILIES OF CHILDREN WITH CEREBRAL IMPAIRMENTS".

Your Eminence,
Dear Brothers in the Episcopate,
Distinguished Ladies and Gentlemen,

I am very pleased to receive you, distinguished participants in the meeting held during these days on "Families of Children with Cerebral Impairments." First, I would like to acknowledge the kind words of Cardinal Alfonso López Trujillo, President of the Pontifical Council for the Family, which has organized this praiseworthy initiative in conjunction with the Centre for Special Family Education (CEFAES) and the Pontifical Council for Pastoral Assistance to Health-Care Workers, whose President, Archbishop Javier Lozano Barragán, is also present at this audience.

The family, as an integrating framework for all its members, is a community of solidarity where love becomes more responsible and concerned even for those who, because of their special situation, need closer, more patient and loving attention from all the members and more concretely from the parents. Within society there are a number of tasks or forms of social mediation which the family can and must carry out with particular competence and effectiveness, in conjunction with other institutions. As a social subject, the family's participation frequently opens many doors and creates a well-founded hope for its own children's recovery. This is precisely the context you address, with the collaboration of researchers, experts and persons involved in this field. Therefore, I am pleased to encourage your work and the concern that spurs you to help families with these needs.

The family, a place of love and concern for its neediest members, can and must be the best place to collaborate with science and technology in the service of health. At times some families are put to the test—a harsh test—when children are born with cerebral impairments. These situations require fortitude and special solidarity from parents and other family members.

The Lord of life accompanies families that welcome and love children with serious cerebral impairments and know how great their dignity is. They also recognize that the origin of their dignity as human persons is in being the beloved children of God, who loves them personally with an everlasting love. Supported and protected by divine love, the family becomes a place of commitment and hope, since all the members concentrate their energies and care on the welfare of their children in need. In fact, you are both the privileged witnesses and the proof of all that true love can achieve.

As is demonstrated by the projects being undertaken in various nations—for example, the Leopold Programme—through patient, diligent and well-disposed attention to the possibilities offered by science and within families, surprising results are being achieved in the rehabilitation of children born blind, deaf and mute. This is a miracle of love, as it were, that does not only permit the brain gradually to develop, but makes the child the centre of all its attention. With this help and everyone's cooperation, the entire community of love and life which is the family grows and is formed in God's presence and fatherly sight. He gives them new energy in their pain and serenity in their suffering, in order to accept illness and, in many cases, to seek the most satisfactory remedies and solutions.

The family is an irreplaceable community in these situations, not only because of the enormous cost of certain treatments provided by health-care institutions, but also because of the quality, talent and tenderness of the loving care which only parents can unselfishly offer their children. These families, without having their attention to their children replaced, must receive the help they need from the surrounding community and society as a whole in order to make this attention more effective. In this regard, it is necessary to point out the importance of parents' associations that seek to share experiences, assistance and technical means in the service of families with these needs.

Programmes and activities like those you have in your hands, which rely on the Church's support, are an extension of the Gospel of life from the family itself. Continue, then, with your gaze focused on the home in Nazareth, whose centre was the God-Child. In fact, the sword of sorrow (cf. Lk 2:35), illumined by the hope that comes from on high, was not lacking in the Holy Family. Like Mary, who with a contemplative soul kept everything in her heart and pondered over it (cf. Lk 2:19-51) in obedience to God's will, may you too, with fervent faith and charity, bring hope to many other families by your commitment and experience.

With these heartfelt sentiments, as I invoke abundant gifts from the Lord upon your persons and activities in this very important area of family life, I affectionately impart to you my Apostolic Blessing.

Solidarity Based on Authentic Faith

ON THURSDAY, JUNE 19, 1997, THE HOLY FATHER CONGRATULATED JEAN VANIER ON RECEIVING THE PAUL VI AWARD FOR HIS WORK WITH THE DISABLED

Your Eminences,
Dear Brothers and Sisters,

1. I offer my cordial greetings to you all, gathered here for the presentation of the prize awarded by the Paul VI Institute of Brescia in memory of my venerable Predecessor, born in Concesio precisely 100 years ago. So far this prize has been awarded mainly to outstanding figures in the world of culture and art. This year for the first time it is being awarded to a representative of that Catholic world which is actively involved—with well-founded inspiration and theory—in the area of human formation and charity, and I am particularly pleased to present it personally to Mr. Jean Vanier, founder of the Community of L'Arche. He is a great spokesman for the culture of solidarity and "the civilization of love," in the fields of both thought and action, in his commitment to encouraging the integral development of every man and the whole man.

I have already had the pleasure of twice welcoming Mr. Vanier here in the Vatican, in 1984 and in 1987, together with representatives of the communities he has founded. Today's occasion is a fitting opportunity to express the Church's gratitude for a work that supports persons with disabilities in a much-valued Gospel style which offers an

original social service and at the same time an eloquent Christian witness.

I greet dear Bishop Bruno Foresti of Brescia, and I thank him for the words he has just addressed to me. I welcome the directors of the Paul VI Institute, and in particular its President, Dr. Giuseppe Camadini, and Archbishop Pasquale Macchi, who was so close to Pope Paul VI. Once again I express to everyone my appreciation of the many projects promoted by this praiseworthy institute and especially for this award, which in some way continues the special attention the Servant of God Paul VI paid to individuals recognized by contemporary man as "teachers" because they are first and foremost "witnesses" (*Evangelii Nuntiandi,* no. 41).

In awarding this year's prize, reference has appropriately been made to the Encyclical *Popularum Progressio,* which Pope Paul VI promulgated 30 years ago, calling everyone's attention to the spiritual and moral demands of authentic development. Today, as an important recognition is conferred on Jean Vanier and the Community of L'Arche, let us thank the Lord for inspiring and fostering in his Church concrete signs of hope which show how it is possible to live the Gospel Beatitudes in everyday life, even in situations that are sometimes complex and difficult.

2. In a message addressed to a group of pilgrims of the Faith and Light Association, who came to Rome in 1975 for the Holy Year, Paul VI wrote that attention to handicapped persons is "the most important test of a fully human family, of a truly civilized society, *a fortiori* of a Church that is authentically Christian" (*Insegnamenti di Paolo VI,* XIII [1975], p. 1197).

On the path it has followed for more than 30 years, as the President of the Paul VI Institute reminded us, L'Arche has become *a providential seed of the civilization of love,* a true seed and the bearer of an obvious dynamism. This is evident from its remarkable expansion in many regions of the world: it is present in 28 countries on the five continents. However, it is not limited to philanthropy nor even to mere assistance. Despite its growth and expansion, L'Arche has been able to preserve its original style, a style of openness and sharing, of attention and listening which always considers the other as a person to be accepted and deeply respected.

Doubtless this is due to the *spiritual dimension* that Mr. Jean Venier has always known how to put at the heart of the Community of L'Arche. It is an eloquent message for our time, which thirsts for solidarity but especially for a spirituality that is authentic and profound.

In this regard, how could we fail to think spontaneously of Fr. Thomas Philippe, a Dominican who inspired and encouraged Mr. Vanier to take the path to which the Lord was calling him? Subsequently he always accompanied him with his prayer and his presence. Today we pay a fervent tribute of gratitude to him who now lives in the "Arche of heaven."

And how could we not remember all those men and women who surrounded the different communities of L'Arche with their silent and generous service? The distinction conferred today is also meant for all these people. It particularly honours individuals with handicaps, from the first two whom Mr. Jean Vanier took into his home, to the great number of those who currently belong to L'Arche. Indeed, they are the principal figures of L'Arche, who with faith, patience and a fraternal spirit make it a sign of hope and a joyful witness to the Redemption.

3. As I warmly congratulate Mr. Jean Vanier, I hope that the work founded by him—as a whole and in every community—will always be accompanied by the light and strength of the Holy Spirit, to respond fittingly to the Lord's plan, thus alleviating the suffering and needs of so many brothers and sisters.

Finally, I invoke the constant protection of Mary most holy and cordially impart to you and particularly to the Paul VI Institute, as well as to the founder and the members of L'Arche, a special Apostolic Blessing.

The Experience of Suffering Must Be Included in the Spiritual Journey Towards the Great Jubilee

THE POPE'S PRAYER FOR MOTHER TERESA OF CALCUTTA AT THE VOLUNTEERS IN SUFFERING CENTER IN MARINO, ITALY ON SEPTEMBER 6, 1997.

Dear Brothers and Sisters!
Brothers in the Episcopate!

1. I am especially glad about our encounter here and extend my most cordial greeting to each of you, affectionately remembering, in particular, those who, undergoing the discomforts of the trip, have wanted to be present for this gathering, even though coming from far away.

This year you are commemorating the fiftieth anniversary of your meritorious Association, which arose in Rome through the work of the Servant of God Monsignor Luigi Novarese, assisted by Elvira Myriam Psorulla, whom I thank for the words by which she has conveyed the feelings of all present today. She has wished to reaffirm the whole Association's resolve to serve Christ in the suffering through a singular work of evangelization and catechesis which situates personal, direct action by the disabled themselves in the foreground.

Monsignor Novarese—who from heaven is surely continuing to accompany this work, which flowed from his priestly heart—is spiritually present among you. And with him all the "volunteers in suffering" are close who over the course of this half century have left this world, taking with them the viaticum of sharing in the mystery of the Cross of Jesus.

2. As an initial core, your Association had the Marian Sacramental League, founded in 1943. Monsignor Novarese by this initiative sought to respond to what the Virgin had requested in the apparitions in Lourdes and Fatima. In addition, he wanted to take up the invitation of my venerated Predecessor, Pius XII, concerning the consecration of the world to the Immaculate Heart of Mary.

He knew that Mary Herself, united to her Divine Son at the foot of the cross, teaches us to live through suffering with Christ and in Christ, in the power of love of the Holy Spirit. *Mary is the first and perfect "volunteer in suffering,"* who joins her pain to the sacrifice of her Son so that it will take on redemptive meaning.

You have arisen from this Marian matrix, dear "Volunteers in Suffering," who carry on this extremely valuable apostolate in the Christian community. You form part of that great movement for ecclesial renewal which, faithful to the Second Vatican Council and attentive to the signs of the times, has found new energies to work intrepidly in the field of evangelization, in an area, that of suffering, which is certainly not easy and is filled with question marks.

This pastoral orientation of yours has been explicitly confirmed in the Apostolic Exhortation *Christifideles Laici,* in which, as regards "pastoral action for and with the sick and the suffering," it is stated: "The sick, the disabled, and the suffering [should not be regarded] simply as the goal of love and service in the Church, but rather as an *active, responsible subject in the work of evangelization and salvation"* (no. 54).

On the occasion of the Holy Year of Redemption, I myself wished to offer the Church—through the Apostolic Letter *Salvifici Doloris*—a meditation on the salvific value of human pain (cf. AAS 76, 1984), and I am grateful to you for having contributed to disseminating this message by the silent witness of your lives, in addition to your words.

3. Dearest brothers and sisters, the woman responsible for your Center, in setting forth the attitude which the Founder would have today, has promised to *cooperate* intensely through prayer and sacrifice *to prepare the Great Jubilee of the Year 2000.* Thank you for this contribution of yours. It is extremely useful and valuable.

The word Jubilee suggests the idea of joy, exulting, and at first glance might thus seem to be in contrast with the condition of those suffering. In reality, it would be if we limited ourselves to a purely human consideration. But, in the perspective of faith, we understand that there is no Resurrection without the Cross. We then understand not only that suffering can coincide with joy, but, indeed, that only under the sign of the Cross can we arrive at true, consoling Christian joy. There can be no authentic *preparation for the Jubilee* unless the experience of suffering, too, in its varied forms, is included in the spiritual journey.

4. The major objectives which the Church proposes for us in these three years of travel towards the great event of the Jubilee cannot be reached without the sacrifice of Christians on a personal and community level, in union with the one redeeming Sacrifice of Christ. In this regard, your Association can make its specific contribution by helping the faithful subjected to trials not to feel excluded from the spiritual pilgrimage towards the year 2000, but, on the contrary, *to walk at the forefront*, bearing the glorious Cross of Christ, the only hope of life for mankind of all times.

An extraordinary example of this silent mission of charity which arises from constant contemplation of Jesus on the cross is Mother Teresa of Calcutta, who returned to the Father's House just yesterday. This morning with deep personal emotion I celebrated Holy Mass for her, an unforgettable witness to a love turned into concrete, unceasing service to the poorest and most marginalized brothers and sisters. In the faces of the needy she recognized the face of Jesus, imploring from the height of the Cross: "I am thirsty." And with generous dedication she grasped this cry from the lips and the hearts of the dying, of the least ones who were abandoned, of the men and women crushed by the weight of suffering and loneliness.

Tirelessly traveling the roads of the whole world, Mother Teresa marked the history of our century: she courageously defended life; she served all human beings, always promoting their dignity and respect for them; she brought "life's defeated ones" to feel the tenderness of God, a loving father to all of his creatures. She bore witness to the gospel of charity, which is nourished by the free gift of oneself until death. We recall her in this way, asking that she may receive the reward awaiting every faithful servant of the Kingdom of God. May her luminous example of charity be a comfort and stimulus for her spiritual family, for the Church, and all mankind.

Dearest brothers and sisters, I thank you once again for this festive encounter and hope that your activity as an association will benefit from the fiftieth anniversary. In requesting the motherly protection of the Virgin Mary, from my heart I impart a special Apostolic Blessing to those present here and to all the Volunteers in Suffering, along with the Silent Workers of the Cross and the members of the Marian League of Priests.

Topics

The Role
of the Diocesan Bishop
in the Health Ministry

Human Cloning

The Rights
of the Sick Elderly

The Demands
of Health and Morality

The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry

A STATEMENT OF THE ADMINISTRATIVE COMMITTEE OF THE UNITED STATES NATIONAL CONFERENCE OF CATHOLIC BISHOPS

The NCCB Ad Hoc Committee on Health Care Issues and the Church prepared this statement in order to respond to concerns among bishops, sponsors, and other Catholic health care leaders to maintain and strengthen the Catholic presence in the rapidly changing health care field. The document was developed in collaboration with the Committee on Canonical Affairs following consultation with the National Coalition on Catholic Health Care Ministry, and canonical, theological and health care experts.

In March 1997, the Administrative Committee of the Nation Conference of Catholic Bishops approved the publication of *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry* in its own name. The statement is authorized for publication by the undersigned.

Mgr. DENNIS M. SCHNURR
General Secretary NCCB/USCC
March 25, 1997

Catholic health care participates in the apostolic activity of the local Church because it is an expression of the healing ministry of Christ. Speaking to Catholic health care officials during his 1987 visit to the United States, Pope John Paul II said: "Your health care ministry... is one of the most vital apostolates of the ecclesial community and one of the most significant services which the Catholic Church offers to society in the name of Jesus Christ" (*Origins* 17 [1987], 292). The Church enjoys a grace-filled tradition in the provision of quality health care in the United States.

The Gospel Context of Health Care

The Catholic Church is involved in health care because it believes that care of the sick is an important part of Christ's mandate of service. The Gospel accounts of Jesus's ministry chronicle his acts of healing. The Gospels are filled with examples of Jesus curing many kinds of ailment and illness. In one account, our Lord's mission is described as the fulfillment of the prophecy of Isaiah: "He took away our infirmities and bore our diseases" (Matt. 8:17; cf. Isaiah 53:4).

Since the principal work of Christ was our redemption from sin and death, the healing that he brought us went beyond caring only for physical afflictions. His compassion for the poor, the sick and the needy fit within his larger mission of redemption and salvation. Christ touched people at the deepest level of their being. As the source of physical, mental and spiritual healing and well-being, he described his work as bringing life in abundance.

Christians see care for the sick and maintenance of health within the context of Christ's example. Hence, to understand the significant role of the Catholic Church in health care throughout the centuries, one needs to look at the faith of those who have attempted to imitate the love, compassion and healing of Jesus. It is nothing less than Christian love that animates health care within the Church. The work of healing and the acts of compassion that envelop it are seen as a continuation of Christ's mission that is enabled by his life-giving grace. It is out of this context of faith, hope and love that the Catholic health care ministry came into existence.

Historically, religious communities of women have taken the lead in this country in the development of Catholic health care ministry. While there are many health care organizations sponsored by individual dioceses, religious communities of men, or other associations of the faithful, the vast majority of Catholic health institutions are sponsored and directed by communities of women religious who have made this ministry an integral part of their religious apostolate. In diocesan churches all over this country, health care ministry has been initiated and continues to be nurtured and sustained by the commitment in faith of women religious. Their efforts have resulted in an extraordinary array of health care organizations that reflect and embody the care of the Church and the love of Christ for the sick.

Challenges and Opportunities

The Catholic health care ministry in the United States stands at a critical moment in its history. Some of the changes contributing to this critical moment are: the fact that the delivery of health care is not as frequently centered in the hospital; the development of integrated delivery networks; the shift of risk from insurers to providers through managed care and capitation; the increase in institutional partnerships; and staff reductions in order to achieve cost savings.

How Catholic health care organizations can best be structured to respond to these developments and to future needs is the challenge of the moment. Regularly, market

pressures drive Catholic health sponsors and other leaders to reassess and even significantly to restructure their organizations in an effort to remain a part—an important part—of today's health care delivery.

This is not only a time of challenge but also a moment of opportunity for Catholic health care. In the words of a recent resource document of our Ad Hoc Committee on Health Care Issues and the Church, *The Responsibility of the Diocesan Bishop for Strengthening the Health Ministry* (1996), as diocesan bishops we should embrace the opportunity to "initiate and coordinate cooperation among acute care facilities, nursing, rehabilitation and long-term services, health clinics, Catholic charities, social service agencies, parishes, schools and religious education programs".

Responsibility of the Bishop

Catholic health care, as an expression of the healing ministry of Jesus Christ, participates as an ecclesial ministry in the apostolic mission of the Church in the same way that other ministries do. The varied and complex structures that are employed to deliver such ministry are a special concern of the religious institutes, sponsors, boards, and other leaders who conduct this corporate ministry. But this ministry necessarily also involves the diocesan bishop, who has a responsibility for the local Church and the exercise of all ministry within it. The bishop has the right to exercise his authority over all apostolates in his diocese, including that of health care, in accordance with the Code of Canon Law and any particular law that he may legitimately enact. Sponsors of apostolates, including health care facilities, must give due recognition to the lawful authority and role of the bishop. This is the teaching of the Second Vatican Council and the universal law of the Church (see, for example, *Lumen Gentium,* 20; *Christus Dominus,* 11; Can. 394, §1; Can. 216; Can. 223, §2; Can. 375; Can. 381, §1; Can. 391, §1; Can. 392; Can. 678; Can. 680).

There are a variety of ways in which the pastoral role of the diocesan bishop can be expressed in health care ministry. The bishop, as principal teacher, elicits openness and receptivity to the splendor of truth, by proclaiming the Church's teaching and by ensuring the moral and doctrinal integrity of Catholic health care (LG, 23; Can. 753; 756; see also *Veritatis Splendor,* 4). As sanctifier, the bishop exercises his ministry by ensuring the celebration of the sacraments for the sick in health

care settings throughout the diocese and in the parishes (*Sacrosanctum Concilium,* 22; Can. 835; 771, §1). The bishop as pastor governs the particular church in ways that seek appropriately to coordinate the healing ministries in the interest of the common good (Can. 394, §1; 223, §2).

In the area of pastoral governance, the bishop's responsibilities vary according to the canonical status of the health care organization, the canonical status of the sponsor, and the canonical issues involved. In regard to all Catholic institutions within the diocese, it is the bishop's responsibility to ensure doctrinal and moral integrity in the witness and practice of each institution. It is the responsibility of the diocesan bishop, in cooperation with religious and other sponsors and all involved in the ministry of health care, to ensure that the Catholic identity of all health organizations is maintained and strengthened. It is also the diocesan bishop's responsibility to coordinate all apostolic activity within the diocese, with due regard, however, for the particular character of each apostolate (Can. 394, §1), thereby fostering and promoting that unity in diversity which characterizes true ecclesial communion.

Recent developments in health care delivery, particularly those which involve substantial modifications in the canonical or corporate status of a Catholic health care organization, often give rise to questions concerning the applicability of Church laws governing the administration of temporal goods, the alienation of Church property, the fulfillment of the intentions of founders, benefactors and donors, and effective control of a Catholic health care organization. The diocesan bishop, sponsors and other leaders must assess the applicability of such laws and evaluate proposed arrangements in the light of Catholic identity and the relevant laws of the Church. Dialogue in such matters is most fruitful and should occur at the earliest stages of considering any venture, affiliation, or relationship that has the potential substantially to affect the mission, Catholic identity, or canonical or corporate status of a Catholic health care organization.

Fostering Collaboration

Collaboration among all involved in the Catholic health care ministry, including Catholic social agencies such as Catholic Charities, is essential because bishops, sponsors and other leaders approach the ministry from complementary perspectives which result from various levels of their involvement in the ministry and their differing responsibilities for the apostolates in the local Church. The diocesan bishop is in a unique position to foster this collaboration, and has a canonical duty to do so. As the recent Ad Hoc Committee statement, *The Responsibility of the Diocesan Bishop for Strengthening the Health Ministry,* asserted in its opening paragraph: "Throughout

Catholic health care ministry today, there is a renewed commitment to cooperation and collaboration among bishops, sponsors, and health care leaders. They are seizing the moment to pool the immense spiritual and material resources invested in this ministry in order to ensure its future viability and effectiveness. Indeed, recent developments—especially the New Covenant initiatives which have brought together bishops, sponsors and leaders in an unprecedented effort to encourage greater collaboration among Catholic health care providers on a national level—have created a particularly auspicious environment for the exercise of episcopal leadership in this area."

The leadership of the diocesan bishop is best exercised in collaboration with sponsors and other leaders who have devoted their energies to the health care ministry with exemplary consistency and vigor, and who, together with the bishop, seek to ensure the continuance of this vital ministry in a rapidly changing environment.

The religious superiors, sponsors and other leaders of our Catholic health care systems have initiated a series of creative ventures in response to developments in the national health care industry that have a direct impact on the institutional provision of Catholic health care in the United States. In exercising their pastoral role in the Catholic health care ministry, diocesan bishops are encouraged to invite religious sponsors and other leaders to join in the effort to support and stimulate initiatives that will preserve and extend the health care ministry and ensure its Catholic identity. An important initiative, designed to foster this collaboration, is the National Coalition on Catholic Health Care Ministry which brings together representatives of the bishops, sponsors, and other health care leadership to develop a common vision for Catholic health care in the United States.

Practical Issues of Collaboration and Coordination

Given the complexity of the new developments in the health care field that need to be addressed and the intersecting competencies that need to be respected, the effective exercise of the diocesan bishop's pastoral responsibility in the health care ministry presupposes communication and dialogue among all those involved in the ministry. Such an approach will both strengthen the Catholic presence in health care and contribute to the ecclesial communion of the local Church.

The apostolic activity of religious institutes, in particular, reflects an important element of this communion (*LG,* 44; *CD,* 35; Can. 675, 681, §1; see also *Vita Consecrata,* 48-49). The Code of Canon Law provides direction for the relation of the diocesan bishop and religious superiors in the coordination of such apostolic activity: "Religious are subject to the authority of bishops, whom they are obliged to follow with devoted humility and respect, in those matters which involve the care of souls, the public exercise of divine worship and other works of the apostolate" (Can. 678, §1). At the same time: "In exercising an external apostolate, religious are also subject to their own superiors and must remain faithful to the discipline of the institute, which obligation bishops themselves should not fail to insist upon in cases which warrant it" (Can. 678, §2). For this reason, in coordinating "the works of the apostolate of religious, it is necessary that diocesan bishops and religious superiors proceed after consultation with each other" (Can. 678, §3).

The diocesan bishop's responsibility encompasses not only the health care apostolates conducted by religious of diocesan and pontifical right but also those initiated and conducted by the Catholic laity as well. Thus the diocesan bishop can foster the kind of collaboration among these apostolates that will strengthen the health care ministry overall and guarantee that they are conducted in accord with the moral teaching of the Church. In this way, the diocesan bishop will fulfill his responsibility to be vigilant about the Catholic identity of any individual or group operating within his diocese.

In order to provide a common basis for collaboration and dialogue, the diocesan bishop and his staff should strive to become informed about the complexities of the current health care environment, while sponsors, administrators and board members need to develop a fundamental grasp of the doctrinal, pastoral and canonical principles that have a bearing on Catholic health care delivery.

An important subject for dialogue among bishops, sponsors and other leaders is, as the *Ethical and Religious Directives for Catholic Health Care Services* state, the assessment of partnerships "that will affect the mission or religious and ethical identity of Catholic health care institutional services" (Directive 68). Sponsors and other leaders make an important contribution to the diocesan bishop's exercise of this responsibility by providing adequate and timely information about developing partnerships. As Directive 68 of the *Ethical and Religious Directives* goes on to affirm, "diocesan bishops and other church authorities should be involved when such partnerships are developed, and the diocesan bishop should give the appropriate authorization before they are completed."

The bishop, sponsors and

other leaders of Catholic health care should give the highest priority to ventures, alliances, mergers or other associations among Catholic health ministry organizations within the diocese or in conjunction with other dioceses. Such collaboration could serve to protect and strengthen the individual and collective well-being of the ministry, as well as contribute to the fuller realization of ecclesial communion. When collaboration with other than Catholic providers is considered necessary or opportune for sustaining and enhancing the ministry, the bishop should be consulted and, when necessary, appropriate approval should be obtained according to the principles of canon law.

In today's national health care market, where collaboration is often seen as essential to vitality and survival, cooperative arrangements often transcend diocesan territorial boundaries. The needed dialogue will often have to draw together bishops, sponsors and other leaders from across diocesan and state boundaries. In pursuit of the common good, it is desirable for diocesan bishops, in consultation with sponsors and other leaders, especially in neighboring dioceses or where local health care organizations belong to systems that cross diocesan boundaries, to strive to cooperate in fostering consistent diocesan policies in their supervision of the health care apostolates of their dioceses, insofar as this is possible. Consultation and collaboration by diocesan bishops at the provincial and regional levels would improve chances for success among new ventures in the apostolate. Contrary or contradictory policies among neighboring bishops can mislead people and do a disservice to the ministry of the whole church. On the other hand, when two or more particular churches unite in a common effort, they witness to the catholicity of the whole Church (*LG,* 23; *CD,* 37).

Diocesan Guidelines and Procedures

Particular diocesan guidelines or procedures, often called diocesan protocols, developed in dialogue with religious sponsors, other health care leaders, and with consultants possessing the requisite legal, canonical and theological expertise, would be helpful to evaluate new forms of health ministry. Procedures should be in place to ensure that there will be a consistent approach to the challenges and opportunities posed by the current health care environment. The form such procedures or guidelines take will vary depending on several factors, among them: the size of the diocese, the diversity of sponsoring bodies, the level of the Church's involvement in health care provision in the local area, and the extent to which multi-state and multi-diocesan interests converge in the provision of this health care. Normally, such procedures would provide guidance for a generally consistent approach to the variety of circumstances that might arise as new collaborative arrangements affecting the Catholic identity of the providers in question are pursued and developed.

Such guidelines or procedures—designed to meet local circumstances and respect legitimate local competencies and interests—may be seen as further specifying the general direction provided by Part VI of the *Ethical and Religious Directives* in this area. In this way, bishops, sponsors and other leaders can pursue together their common objective of ensuring the future of the Catholic health care ministry by fostering the thorough review of proposed affiliations, partnerships, mergers, ventures, and any other relationships that effect the Catholic identity and institutional integrity of the health care provider as well as the Catholic presence in the health care field (*ERD,* General Introduction, p. 4).

Conclusion

As Catholic bishops, we seek to exercise our pastoral leadership in an ever changing health care environment. Already in many parts of the country, on a regional or local level, dialogues are under way to enhance the capacities of bishops, sponsors, administrators, and board members to exercise their distinctive roles of leadership in sustaining and revitalizing the health care ministry of the Church. Following the first New Covenant national gathering under the auspices of the National Coalition on Catholic Health Care Ministry, the Catholic Health Association, and Consolidated Catholic Health Care, local gatherings have provided forums for all the involved parties to come together and from various perspectives to address a plan for future ministry in the Church. Such forums should help to create an atmosphere of mutual understanding and fruitful collaboration in which creative initiatives can emerge to meet the needs of our communities.

This call for the exercise of the bishop's pastoral office is issued to make this collaboration more effective. Out of such cooperation and with the pastoral direction of the diocesan bishop, Catholic health care organizations will continue to manifest the teaching and love of Christ through their caring ministry that serves the whole person—body, mind and spirit—embracing that person with all of the compassion and love which says to the sick, the infirm, and all those in need of health care, "As Christ would reach out to touch and heal you, so, too, do we."

Human Cloning

Introduction

The recent publication in the journal *Nature* of an article with information on the successful cloning of a sheep, starting from the cell of an adult,[1] has unleashed an avalanche of commentaries in the media. The scientific and ethical repercussions of this experiment are considerable. However, many of the opinions expressed as a result of this news betray a healthy dose of fantasy and require clarification. To provide such clarification, we shall describe the experiment conducted, its precedents, the scientific conclusions which may be derived from it, and the ethical repercussions of its possible systematic application in a future which, until a short time ago, seemed quite distant.

Precedents

The attempt at obtaining living beings from somatic cells has been a concern of scientists for some time. However, the experiments carried out had never yielded satisfactory results. At most, tadpoles had been obtained by inserting the nuclei of embryonic amphibian cells to replace the original nucleus of the ovule or the egg, but there had been no success in developing an adult specimen.[2]

The habitual interpretation of these failures cited the loss of the totipotency of the embryonic cells very early in development, when parts of the genome are assumed to be in the process of activation or repression, in such a way that the state of the DNA in the nucleus of the cell of an adult is quite different from that of the just-fertilized ovule; the adult's proves unable to manifest adequately the whole sequence of orders needed for development and morphogenesis.

For this reason, in the experiments conducted, there has been a tendency to use embryo cells: from as early a stage as possible. These cells are thought still to possess, to a great extent, the totipotency which is lost in the adult's cells and are thus better candidates for successful cloning.

Embryo Fission

The simplest direction for work is embryo fission: to divide a few cells from the embryo, in such a way that each of the resulting cells produces a complete adult being. Accordingly, even in the last decade there was successful division of very early mouse embryos, and several specimens were obtained from one.

This direction (to use embryo cells) was the one followed by Hall and Stillman in 1993[3] and also aroused interest, basically because it had been pursued with human embryos. This experiment did not involve special technical complications. The researchers took seventeen embryos of from two to eight cells which remained after the practice of in vitro fertilization: they were not normal embryos, but triploids, the result of the fertilization of an ovule by more than one spermatozoon, a relatively frequent phenomenon during the practice of the techniques of assisted reproduction. These triploid embryos are not viable and were to be discarded. The researchers withdrew them from their zona pellucida and subjected them to micromanipulation to divide them, thereby obtaining forty-eight embryos, which they placed in a cultivation medium with sodium polyalginate, which replaced the original zona pellucida and permitted further growth of the divided embryos.

The results were as follows. When the original embryo was eight blastomeres, prior to excision, the new embryos developed at most to the stage of eight cells. It they were four blastomeres, they could reach sixteen cells. And the embryos resulting from division at the stage of two blastomeres arrived at thirty-two cells, in good condition; it is not known whether the latter would have developed more. Hall and Stillman decided to interrupt the experiment at that point. It would have been necessary to implant them to continue their development.

Their experiment had two aims. The first—theoretical and primary—was to determine whether, as was assumed, human embryo cells at the morula stage possessed the totipotency usually attributed to them. The experiment, while apparently confirming this assumption, at least for the embryonic stage of two cells, is rather questionable in its conclusions. It was carried out on triploid, nonviable embryos; we thus do not know what might happen with normal embryos. As for these, we can only suspect that the same would occur, as we previously assumed with veterinary knowledge and studies on spontaneous twinning in man. In short, the experiment did not contribute practically any significant knowledge to science (the possibility of replacing the zona pellucida with polyalginate gel had already been discovered by Dr. Hall's own team in 1991).[4] In addition, once the first flush of fame which had earned them a prize had passed, serious doubts were raised as to the technical and ethical propriety

of such experiments. Since there had been no approval of the experimental protocol by an independent ethics committee for research, Stillman and Hall had to return the prize received and were subjected to other sanctions.

The second purpose of their experiment was practical: to increase the effectiveness of in vitro fertilization. It has been known for some time that some women submitting to the techniques of assisted reproduction do not react adequately to hormonal stimulation, and their ovaries produce a small number of ovules. Since the effectiveness of in vitro fertilization is linked to the transfer of a sufficient number of embryos, a procedure was sought to improve the effectiveness of the technique in those women who react poorly to hyperstimulation of the ovaries and do not accept donated ovules. That could be obtained through cloning: by dividing one embryo, or the few obtained, into several. The couples with few ovules would thus have a similar chance to have a child, as compared to those with many. Moreover, with the cloning of the embryos obtained, the dose of hormonal stimulation now received by the women submitting to in vitro fertilization could be reduced: a stimulation apparently increasing the risk of certain gynecological cancers and, on occasion, producing a clinical syndrome which may have serious consequences.

The problem of this technique used to improve the effectiveness of in vitro fertilization is that it is not very reliable. In view of the high number of deaths of embryos, even in the absence of manipulation, the attempt to clone may destroy the slight hopes of having a child: the straw that broke the camel's back. And we know that human embryos are much more delicate than bull calf embryos, on which the division of embryos from choice races is being successfully practiced (though with very low effectiveness as well). Cloning embryos does not appear to be a real solution to this problem.

Furthermore, arguments of an ethical nature opposed cloning, largely agreeing with those made public as a result of the experiment on the sheep Dolly. We shall examine them after considering the technical aspects.

The Experiment of Wilmut et al.

Though the news traveling around the world refers to the latest research work by the team at Roslin Institute, the success of their technique was already published last year: on that occasion, however, the cells from which they started were embryo cells.[5] The procedure consisted of taking cells and placing them in cultivation. The nutritive medium, in successive stages, diminished its concentration of nutritive proteins, from 10% to 0.5%. In this way, it was possible to halt the division of cells in cultivation. Furthermore, ovules were taken and their nucleus was extracted by aspirating through a micropipette. As a final step, the cultivated cells and the enucleated ovules were placed in contact and subjected to a brief electric pulsation for two purposes: on the one hand, to create micropores in the membrane of the two cells placed in contact and produce a fusion; on the other, to open the calcium channels in the membrane, provoking a reaction similar to the one caused by the spermatozoon on fertilizing the ovule and starting up the whole cell metabolism and the development of a new being. This technique was basically the same when embryo cells were used to start from or cells from the udder of an adult sheep, with variations only in the number of steps in cultivation.

The effectiveness of the technique was very low: from the fusion of 277 enucleated ovules with the corresponding cultivated cell only 29 embryos were obtained and transferred to sheep. From them only one lamb was born, Dolly. As can be grasped, this experiment is not exactly cloning, for the new living being is not produced exclusively from an adult cell, but from fusion with an enucleated ovule. In any case, the adult specimen obtained is genetically identical to the cell from which they started.

Scientific Repercussions

The journal *Nature* itself devotes an article to commenting on the repercussions of the experiment's result from a scientific standpoint.[6] According to this commentary, its importance lies in the empirical demonstration that tissue differentiation during development does not involve irreversible changes in DNA; the mere "stoppage" of cell reproduction seems to reprogram[7] the genetic system and enable it to begin embryonic development again until reaching adulthood.

Unfortunately, current prejudices about the role of the genome in development have impeded timely use of this occasion to go somewhat further in analysis of the theoretical consequences of the experiment. The hypothesis usually maintained on embryonic development assumes that it takes place through programmed activation and repression of different genes involved in the morphogenesis and differentiation of tissues. The existence of activating and repressing genes is demonstrated for certain very concrete cases. However, embryologists have known for some time that, in contrast to what might be deduced from this purely genetic hypothesis on development, most tissue differentiations do not require specific substances as inductors. Simple physical or chemical changes may produce tissue differentiation in the absence of the usual inductor. The action of any pharmaceuticals or physical agents may interfere in embryonic development, producing the same malformations, whenever such action takes place at a time in which tissue is sensitive to external influences.

These phenomena are simply inexplicable by means of the intricate interplay of activators, repressors, programmers, homeotics, and so forth whose activity is, by definition, specific.

In inclining towards the hypothesis of genetic programming, current research has closed its eyes to simple phenomena of cell interaction, of specialization through autonomous progression of cell functions associated with homotypical and heterotypical interactions which are well known in experimental embryology. There is a search in gene programming for what, in all probability, is not to be found therein. Hence the current disconcert: geneticists are learning more and more about genes, but the general panorama as regards cell functioning and embryonic development is daily getting more bewildering and obscure.[8] The current moment of surprise is a good occasion to carry out a critical revision of our knowledge of genome functioning during embryonic development. Hopefully, we will have the courage to throw out some heretofore widely-accepted hypotheses which Dr. Wilmut's experiment has begun to undermine.

Moreover, with a more objective vision of embryo development—free from the current obsession with genetic explanations—some proposals for applying recent cloning techniques are simply impossible. Concretely, it has been proposed that the knowledge gained from the cloning technique be used to induce the differentiation of certain tissues, starting from somatic cells. Such tissues may be used for grafts and transplants: e.g., skin for burn victims, bone marrow in cases of leukemia, or nerve tissue to treat Parkinson's disease.[9] This proposal does not consider that the only way to induce the appearance of mature cells, starting from immature ones, is through complex interaction with other tissues, as embryologists well know: differentiated tissues may be obtained only in a complete embryo. The proposal to discover the keys to genetic programming and its application to obtain specific tissues is impossible, since it starts from an error concerning the basic concepts of embryology.

Ethical Repercussions

The application of this cloning technique to livestock and its possible application to man in the relatively near future—after a sufficient period of experimentation—has prompted reactions, many of them critical. However, these possible applications are not

science fiction. Dr. Wilmut estimates that significant progress can be made in two years of research.[10]

In the case of application to animals, the greatest criticism has been aimed at the diminishment of biodiversity in the cloned species: breeds with unsurpassable qualities for the production of meat, milk, and so on might be obtained, but at the expense of having a very homogeneous population which might completely succumb in the face of an epidemic which would equally affect all specimens. However, it must also be recognized that this application proves rather problematic from a commercial standpoint: it involves the manipulation of embryos and, therefore, lower survival rates than in the techniques of in vitro fertilization already carried out on livestock. The latter are seldom used because they are not very successful and must be applied to young cows in their first pregnancy alone. It is thus appropriate to foresee very serious difficulties before the technique becomes commercially viable to improve livestock production.

Quite a different question is their application to clone very special animals; accordingly, to clone animals in imminent danger of extinction has been proposed. In more immediate terms, there is a possibility of cloning genetically manipulated animals so that they will produce products in their milk which are uncharacteristic of it, but highly useful for human therapy. In this regard, there are already sheep and goats producing factor VIII and other therapeutically useful products in their milk. Since the method for obtaining a transgenetic animal to segregate a specific product in milk is rather difficult, the new cloning technique would circumvent new recourse to genetic manipulation: it would suffice to clone some of their cells to have an inexhaustible source, without subjecting the animal to cruel treatment for this purpose. Under this heading we could also include the research currently being done to obtain transgenetic animals as organ donors for human transplants. Though still rather questionable in regard to its practical application, it is a promising area of research which could yield large-scale results only by incorporating cloning techniques associated with the transgenetic animals obtained. Another application would be the cloning of animals in which an adequate model for certain human diseases existed, in such a way that different treatments might be attempted in a controlled manner, a matter which at present seems nearly impossible. Similarly, the number of animals used in experimentation could be reduced, with the availability of perfectly identical specimens on which to test the various alternative procedures.[11]

As for human cloning, the opinion of Dr. Wilmut him-

self—and that of many other doctors—is clear-cut: although cloning in man appears to be technically possible, it should not even be attempted, for it presents itself as an aberration lacking clinical utility.[12] Furthermore, attempting human cloning—for the purpose of recovering a deceased person—would obtain nothing but a different person, though physically identical to the deceased, like a twin brother born later. This new person would be influenced by his own cultural situation, experiences, family, life options, and so on. It would thus be pure chance to manage to have an Einstein, a great athlete, or an artist once again by cloning one of that person's cells.

From a deontological standpoint, in support of this commonsense opinion, we would have to argue for the respect due the human being as an embryo.[13] If the technique used for cloning gives rise to so many failures (deaths of human beings at an embryonic stage), their application is not acceptable until these defects are reduced to a tolerable minimum. Moreover, when this practice is not applied for diagnostic or therapeutic purposes, its medical use seems unjustifiable.[14]

This deontological viewpoint fits in well with the declarations made in the European political context, which refer to basic human rights as a motivation for prohibiting human cloning.[15] In fact, many European countries have prohibited the practice of human cloning in their legislation (including Spain), and the European Commission has also expressed its wish to prohibit the cloning of human beings on a European level.[16]

The problem of prohibiting it is harder to solve in the United States. There the hierarchy of constitutional values is, in general terms, different from the European one, with priority given to freedom above other human rights. In order to be able to prohibit a given activity, on a state or federal level, it must thus be proven beforehand to some degree that it is harmful for other citizens, or for some of them. This is the purpose of the commission President Clinton has established to study the matter. While the commission is deliberating, the president has prohibited federal financing for research aimed at human cloning. Let it be said in passing that this prohibition has not affected anyone, for such research was not being conducted anywhere.

The problem arising in this atmosphere of emphasis on freedom is that there are few who see the harm done to the child produced thereby.[17]

There is finally no distinction between a child's coming into the world and that child's being produced. In this way, the human right to be born as the fruit of one's parents' love and in a family[18] is obscured, and in the end aberrant manipulations are proposed as the most normal thing in the world: just as a family had another child to obtain bone marrow for a transplant for another child of theirs with leukemia,[19] it seems consistent, within this dynamic, for cloning to be posed as a procedure for acquiring spare organs as soon as it is sufficiently effective in getting results. For the time being—thank God—general opinion is almost unanimous in prohibiting human cloning, but only the course of events will show whether that good sense is destined to continue.

Dr. ANTONIO PARDO

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[14] Cfr. *Codice di Etica e Deontologica Medica,* Art. 24.2.

[15] Cf. the statements made by Noëlle Lenoir, member of the French Constitutional Council and Chairman of the European Commission's and UNESCO's ethics committees, to Le Monde, March 4, 1997, 13.

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Document on the Rights of the Sick Elderly

THE ITALIAN SOCIETY OF HOSPITAL GERIATRICIANS

As times evolve, the social culture changes radically.

Throughout history man has always been striving to attain different and ever-higher goals that are necessary for individual and collective development.

In the first millennium man had to face the problems related to survival, to the development of effective strategies of defence, to improve the primary standards of living and become less vulnerable to the countless attacks, both from the outside (e.g. environment and other men) and the inside (e.g. diseases) which would markedly restrict his life expectancy.

In the western world the second millennium ends with the age of social conquests with its focus being the attempt to strengthen the models of social security and protection: man is at the centre of society, the economy is at his service and the social system must not only provide care but also manage the citizen's health and life. The Welfare State comes into being which seeks to meet the needs of people "in need of help."

This is the age of industrialization, economic security and longer life expectancy, also thanks to improved sanitary conditions and to an increasingly sophisticated respect for biological balances.

Yet duration of life does not necessarily mean quality of life. Thus modern society is moving into the third millennium with the objective of raising the standards of living to a level which is well beyond the "sufficient" level of security and social protection.

The year 2000 is expected to be the Age of Welfare.

According to Art. 25 of the Universal Charter of Human Rights, published by the World Health Organization, "...each individual has the right to enjoy a decent standard of living to grant him, and his family, health, welfare, medical assistance and social services. Also, every individual has the right to be granted social security in cases of unemployment, illness, disability, widowhood, old age or in any other case of loss of means of subsistence due to circumstances occurring against one's will."

The problem arises when a given right is put into effect, with all the commitments that this right involves.

Our society has come to realize that it has neither the instruments nor the means to ensure that what has been established by right can be effectively put into practice.

At this point the problem, hitherto considered as a collective matter, irrespective of age, sex and culture, inevitably starts to involve the elderly.

Indeed, in the face of economic constraints, there is a growing risk that selection criteria will have to be adopted more or less spontaneously in the dispensing of health care.

In a society which is exclusively economy-based and where personal and social values are strictly related to the level of productivity, these criteria are likely to burden classes of people who are not considered as "highly-productive."

As far as the health field is concerned, there could be the risk of a quantitative and qualitative differentiation among therapeutical interventions where the discriminating factor would be the economic productivity of the individual.

It must, however, be borne in mind that this idea is based on a misconception: the concept itself of productivity is strongly conditioned by the structure of our system, which, despite the alleged axioms of adaptability and flexibility, is extremely inflexible in selecting abilities and possibilities for adaptation.

In short, it is true that nowadays the elderly can no longer be a part of the production cycle, but is is also true that our society does nothing to identify, exploit and optimize the elderly's residual potentials at their best so as to adjust the productive system to their possibilities.

According to a totally biased vision of flexibility, it is the individual who has to adapt to the system and not the system that, endowed with inbuilt flexibility, adjusts to what the individual is capable of offering.

As a consequence, facing the preconditions underlying the problem of *the sick elderly* means facing, and at times solving, a number of social and health aspects.

When we have put the issue of the elderly into the right perspective, it is worthwhile taking a further step and asserting that prior to satisfying the elderly's needs it is advisable to intervene on the risk factors in order to prevent such needs from arising.

This is why it is essential to draw up a Charter of the Rights of Elderly Patients: very often the problems relating to the elderly are limited to the assessment, and at times to the satisfaction, of their apparent needs, whereas they should be characterized by a clear definition and acknowledgement of their rights.

It is worthwhile specifying that the term "need" carries

with it the idea of "assistance," whereas the term "right" implies the concept of respect.

The first recalls a passive attitude; the second implies autonomy and responsibility.

The idea of "need" immediately determines an imbalance, with one party being passive and dependent on the other. The concept of right, on the contrary, is inherent in human beings and views people and services as active subjects that are co-responsible in working out solutions to common problems.

At present, law in force in most European Countries protects individuals living in conditions of hardship or weakness, deprived of the means of self-protection (e.g. children), but within the general heading of "elderly" it does not classify the different categories.

Protocol of rights

In order to draw up a correct plan of the rights of elderly patients it is essential to refer to the needs that these rights are supposed to meet.

Taking Maslow's scale (M. 1954) as reference, the rights of elderly patients can be broken down into three categories, according to three classes of needs.

1. The right to have primary or physical needs fulfilled

2. The right to have secondary or psychological needs fulfilled

3. The right to have tertiary or spiritual needs fulfilled

Elderly patients have the right:

– to be respected as persons;

– to have their human dignity respected;

– to have their needs relating to age, gender, culture, religion, lifestyle and relationship respected, also within the health establishments.

1. The right to have physical needs respected

1A. The elderly have the right to receive adequate, personalized and targeted therapeutic treatment

The clinic picture of the elderly is usually characterized by the presence of multiple disorders; thus a global assessment is essential as well as an accurate therapeutic plan in which different interventions are suitably integrated. For this reason the elderly are entitled to a Multidimensional Geriatric Assessment as a diagnostic tool whereby the patient can be fully monitored and an individualized workplan according to the patient's actual needs can be worked out.

– The elderly have the right to receive all possible diagnostic, therapeutic and rehabilitation interventions regardless of their age, even when these interventions involve high costs, in terms of time and means.

– The elderly have the right to be given expert and humane assistance.

– The elderly have the right to have their needs for comfort, affection, psychological and moral support fulfilled.

– The elderly have the right to undergo all possible rehabilitation interventions, including protheses or functional interventions, in order to be restored to their social environment and recover a good quality of life.

– Where no treatment is possible, the elderly have the right to have their physical, psychological and moral pain alleviated.

1B. The right to quality

Both public and home health services for the elderly must be aimed at quality.

It is a difficult and complex process, whose structural features have not all been defined yet and which involves a deeper transformation as compared to the past, when the mere creation of a service was enough to justify its existence.

A fundamental characteristic that needs to be present in order to ensure the quality of geriatric services is the definition of the outcomes, i.e., the precise results that can be obtained for each patient.

These are clearly distinguished from the definition of clinical-care processes, that are an integral part of this work but are not the actual outcome.

Thus the elderly have the right to mobility, to bed sore prevention, but above all they have the right to a personalized treatment plan with specific targets, the attainment of which allows us to assess the quality of the intervention itself.

1C. The right to personal and collective hygienic conditions

– The elderly have the right to make use of all the devices and means that can ensure a decent and acceptable standard of living with full respect for their privacy (tools, aids, protheses, etc.);

– the elderly are entitled to having their personal needs for hygiene and decency respected even if, because of disease, these needs involve a repetitive and compelling effort;

– the right to live in sound socio-psychological conditions that do not impair cognitive and affective functions.

1D. The right to live in a comfortable environment

– Elderly patients have the right to receive care at home for as long as possible;

– they have the right to be ensured easy access, if required, to local health-care facilities;

– the right to environments where architectural barriers have been removed, where they can freely move and live insofar as health conditions permit, and in such a manner as not to cause any physical or psychic stress to themselves or to others;

– the right to have their nutritional, respiratory, heating and evacuation needs met;

– the right to use the means of environmental interaction

in the ways that are best suited to their psychophysical conditions.

This means, among other things, that residential and/or alternative care solutions must be worked out, according to the specific conditions of each individual.

1E. The right to freedom of movement

The elderly have the right to move freely within public places and in their environment.

It is necessary to develop a social culture which respects this need of elderly people, especially when they are disabled or not self-sufficient. This can be done by abolishing architectural barriers and by providing the necessary aids that help the elderly to move about.

2. The right to have psychological, personal and security needs fulfilled

2.A The right to have the needs of protection, security, prestige and social status respected

2B. The right to benefit from social care

The disabled must be ensured house-cleaning help, first aid and help in the preparation and supply of meals.

2C. The right to receive minimum income allowing for decent and autonomous living standards

2D. The right to be informed

– The elderly have the right to be aware of all possible interventions that can be provided, current therapeutic choices and possible side effects;

– the elderly have the right to be constantly informed about their health condition, therapeutic plans and the course of disease;

– they have the right to receive thorough and clear information concerning national and local services, support groups and specialist practitioners who can meet their needs.

2E. The right to management and autonomy of choice in the planning of therapeutic treatment and of living conditions

– The elderly have the right to choose, wherever possible, the persons and the facilities that will look after their health and which will provide care;

– the right to refuse a therapy;

– the right to make use of complementary therapies that do not interfere with the medical treatment being provided.

2F. The right to keep in contact with their family and home

From this standpoint, home-care (e.g. therapy, rehabilitation, supporting action) should be preferred for as long as possible. It is desirable to encourage and promote systems of Integrated Home Care, thanks to which patients can remain in their own environment and with their family members as long as possible.

2G. The right to socialize and communicate

This item comprises all the provisions needed to allow the elderly to make use of all means of communication and information, both in their home life and in health facilities.

It is essential:

– to plan specific activities aimed at prompting the functions of social interaction;

– to provide adequate conditions and activities for the elderly in order to help them keep relational ties with the outside world.

This helps to avoid conditions of sensory deprivation which lead to cognitive deterioration, and to depressive and/or psychotic disorders.

2H. The right to being respected for their social status

Each individual is entitled to being respected for the socio-cultural status attained during his/her working life, even when retired and/or ill. A disease must not be the cause of "personal" decay; rather, it should be considered as a "crucial" moment along the path towards a new evolutionary phase.

2I. The right to make the most of any residual potential at its best

Considering aging as an evolutionary process, the elderly have the right to receive us much help as possible from the social environment in identifying and optimizing their residual potential. When functions are damaged or lost, care-givers should assist the elderly in developing alternative strategies that might compensate for the impaired functions.

2L. The right to be reintroduced into the production cycle

With a view to optimizing resources, the elderly have the right to be reintroduced into the production cycle even if on a different level.

In this way not only can the elderly perform an undoubtedly useful social function, but they can also strengthen their feeling of self-esteem and self-confidence and increase their actual level of efficiency.

3. The right to have spiritual needs fulfilled

3A. The right to respect for the worth of the person and to his/her personal development

The elderly are entitled to respect for their human dignity. A disease often turns an individual into a passive subject of a variety of therapeutic actions the performance of which is often disrespectful of the person's sensitivity and dignity.

Even when affected by disease, hospitalized or when self-sufficiency is lost, the elderly must be considered first of all as "persons."

Any therapeutic and rehabilitating activity must be

provided in full respect for human dignity.

3B. The right to make autonomous choices

The elderly have the right to be guided—with the physician's support and in an open dialogue with the health staff—towards an aware and effective choice.

– They have the right to make assessment openly with the physicians and to choose, autonomously and freely, the diagnostic and therapeutic interventions they must undergo;

– the right to choose the persons who can help and support them in making such choices;

– the right not to be left alone in bearing the burden deriving from the therapeutic choices;

– the right to refuse interventions that are too invasive, uncomfortable and uneventful;

– the right to be informed about and to refuse to take part in a research or experimental project.

3C. The right to have their social, cultural and religious traditions respected

Even when ill, the elderly have the right to be able to follow their traditions, to profess their faith and to comply with its precepts.

3D. The right to receive religious and psychological support

The elderly have the right to express their distress and fears and be comforted by an interlocutor who can listen to and elaborate the moral problems related to ageing.

3E. The right to choose their personal destiny

– Just as the elderly have the right to lead a decent life, the elderly also have the right to experience a decent death.

– The elderly have the right to die with the least pain possible and in as dignified a manner as possible.

– The elderly, especially when terminally ill, have the right to receive care, moral support, company and comfort and to have their psychic and physical pain relieved.

– The elderly should be helped to face death, with great respect and with the emotional (and not only technical) closeness of the persons and facilities that are taking care of them.

Finally, perhaps the most important right that the elderly are often denied: "the elderly have the right to be treated with kindness, in a manner suited to their frailness, insecurity and fear of the future."

In order for a sanctioned right to be really respected it is essential that a new "culture" be created.

We must not forget that in our case our geriatric culture is not always matched by a similar approach in our society.

The very concepts of efficiency and productivity, underlying western society, imply the denial of psychic and physical decay, which perhaps is tantamount to saying that the western world is probably denying the very idea of death.

And so, while in the past the elderly were considered as a model of wisdom and experience of life, a reference point, the keeper of the family and society, of "historic memories," today the prejudices permeating our cultural model induce the younger generations to refuse any sort of identification with the elderly.

Even worse, there is also less willingness to feel problems and discomforts that nobody would ever want to experience.

Our first commitment, then, is to fight for an education in ageing which begins during childhood so that ageing may be viewed in the right perspective as an evolutionary step in life characterized, like any other crisis, by new levels of personal and psychological integration, as well as by the need to adapt to possibilities and potentialities that are different from those of the previous stages of life in terms of quality and not only quantity. In this perspective it is desirable to recover the moral and social values that the elderly embody, by virtue of their rich human and cultural experience, and they can thus represent a source of enrichment and growth for the family and for society.

Dr. STEFANO MARIA ZUCCARO
S.I.G.O. National Secretary
Prof. MASSIMO PALLESCHI
S.I.G.O. National President

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The Demands of Health and Morality: The Health Paradigm in WHO

I. The Christian Vision of the Demands of Health and Morality

A) The Christian Demands of Health

Health should be preserved, in keeping with the commandment "Thou shalt not kill," which in positive terms requires health care. This commandment is based on four principles elucidating it: 1) man's life comes from God, who created him in his image; 2) man must be free to orient his life towards God at all times; 3) God is the only one who gives a beginning and end to life; and 4) God has transformed this life into the life of his sons and daughters. God thus says, "Thou shalt not kill," and in the Last Judgment He will remind us that whatever we did to any of the least ones was done to Him (Mt 25:31-46), in accordance with what is stated in the parable of the Good Samaritan (Lk 10:25-37).[1]

B) Health and Life

As we see, to speak of human health is very complex, for it is worth what man's life is worth. To a certain extent, health and life are identified, and to speak of man's life is to touch upon a whole anthropology, which, as related to the son of God, translates into a theological anthropology. Health and salvation are correlative, are situated in the same coordinates, and are governed by the same canons. Health thus possesses biological, psychological, and social connotations. All consideration of it should be undertaken in a spiritual perspective—that is, from the standpoint of the Holy Spirit, who has been given to us. Only in this way can it be understood in depth.

In fact, in human history we find notable indices in this regard. At first health and, particularly, illness were seen as proceeding from a transcendent world depending on the benevolence or malevolence of superior beings, and at the same time the social dimension was accentuated, since healings were carried out through public ceremonies and rites. With the arrival of the secularist period, all of the foregoing, which connoted a religious side to health and illness, was set aside, and health and illness were given an exclusively biological connotation. Such was the case in the nineteenth century and for several decades in this century, though, if the truth be stated, the psychological and social dimension of health is now beginning to be stressed again, to the point where in Alma-Ata (1978) the World Health Organization defined health as "*a state of complete physical, mental, and social well-being, and not only the absence of maladies and diseases*."[2]

C) Health and Pain

However, if we understand health in a Christian sense in the context of salvation, we see first of all that health amounts to life; it is not set over against pain—rather, pain to some degree contributes to shaping health, when understood globally, since life may be comprehended only in terms of the explanation it receives from the glorious death of Christ the Lord. Life and health are comprehensible only through the resurrection. This concept leads us to regard the Alma-Ata definition of health as a utopian construction, since it is not a reality which can exist.

Complete well-being can exist only in faith, and it is then a question of happiness rather than well-being; accordingly, complete well-being is not necessary to arrive at happiness, for complete well-being can be attained only in the next life and is a utopian conception in this one. For the time being, however, we may pause in our dialogue with WHO, as we shall devote the second part of this commentary to it. We shall now consider only the Christian concept of health, which must nonetheless be approached in terms of our real experience, as it takes place in our context.

D) Quality of Life

Quality of life is usually mentioned nowadays along with the concept of health. Quality of life is said to define the person, to make the person who he is. Quality of life is usually expressed as the set of economic goods needed to live and measured according to the gross national product—though some do not agree now that GNP is a criterion for measuring quality of life because of the environmental problems entailed by growth, and there is thus talk of "net economic well-being," which involves production plus the environment, working conditions, the use of free time, and so on. For others, this well-being is not sufficient to speak of quality of life; rather, all the foregoing is required, with the essential addition of the influence of the family and society on the person, so that quality of life would amount to the subject's natural capacities plus the influence of the family and society. A formula is generally used to describe quality of life: quality of life=natural capacities (fami-

ly/society). The result of quality of life is said to be well-being and, therefore, health.

But things do not appear to be so simple, since ethical problems of great scope are then posed—e.g., if quality of life equals 0 in the formula (that is, if there are no natural capacities in the subject or family/social influence), is it licit to take the life of the subject himself? These are the problems of eugenics and euthanasia, to which Christian ethics give a negative response. Other problems are posed by the question "Whose quality of life?" Can we speak of quality of life and define it as such while prescinding from the world context? Quality of life, in this sense, is usually spoken of for the first world, but the third is overlooked Now then, at the conclusion of this millennium, the first world has barely 20% of the global population; the remaining 80%, on the other hand, are in the third world. The question is thus unavoidable: "Whose quality of life?[3]

This leads us to conclude that quality of life, that of human life, must be measured in accordance with expectations that it may be led in keeping with the life of a child of God whose parameter is the Incarnate Word. Quality of life thus fuses with the sanctity of life, and we must say to this secularized society that the religious dimension is not just an afterthought in health, but the essential thing which truly measures genuine quality of life.

E) The Demands of Health

If we understand health and life in this way, what are their demands? Let us not forget that what we might term "infirmability" is a constitutive element of man, a manifestation of his fragility and mortality, but in Christ it takes on a positive connotation under the aspect of suffering and pain, for in Him pain is positive, as the cause of the redemption of the evil afflicting humanity.

Even if we take the foregoing into account, can we speak of the demands of health, or, even more, of the right to health? I think we can, although, rather than speaking of the right to health, it would be better to speak of the right to the protection of health, in accordance with what we stated previously when speaking of the global concept of health. We may say that there is a right not only to subsist, but to authentic quality of life, and this means access to health care and to necessary measures as regards the dangers to health in the face of which the individual or group feels powerless. This right is limited by human fragility and the real possibilities at a given moment.

In relation to hospital care, there is resistance to speaking of health rights because, on the one hand, a patient's hospital stay is transitory and, on the other, the doctor is not his adversary, but his partner in healing; rather, there is talk of needs which to some extent might be regarded as rights. Some of them have been formulated—e.g., the *Charter for Hospitalized Patients*.[4] Eight points are mentioned: to have access to adequate hospital services, to receive respectful care in keeping with human dignity, to be able to accept or reject all diagnostic or therapeutic procedures, to be informed about one's condition, to receive complete advance information on the risks entailed by any nonroutine procedure in treatment, to maintain privacy in information concerning patients, to have one's religious or philosophical convictions respected and recognized, to be able to present complaints which will be taken into account, studied, and responded to.[5]

The ways of dealing with the exigencies of collective rights in health care have been classified according to four systems. The pure liberal system holds that each should take care of himself as best he can; whoever has money should pay, and whoever does not should turn to charitable support. The humanitarian liberal system holds that whoever can should pay for health care; those who cannot should be taken care of by government. The pure socialist system holds that government should take care of everyone on the same basis. The liberal socialist system holds that government should provide care for all, but that whoever is willing and able to pay should have access to private medicine.[6]

F) Limitations on Health Exigencies

Are there limitations to these rights? There are, both subjective and objective. Subjectively, when the person undergoing an illness freely decides not to seek care; nothing may be done against his express will. Objectively, it is true that Christian love for the health of one's neighbor has no limit, although action must take existential limits into account, such as the real chances of obtaining health. Every life must be cared for according to our current possibilities. When it proves excessively burdensome to obtain health, we are not obliged to do so. In that case, when the means involved are so extraordinary as to prove very difficult, we are not obliged to use them.[7]

II. THE DEMANDS OF HEALTH AND MORALITY IN WHO

Now that we have reflected on certain perspectives in Christian thought, we can contrast them with the exigencies of health and morality in the thought of WHO. We shall first define the field. I shall basically refer to a current WHO document which has struck me as very significant for the topic we are dealing with; only in complementary fashion will I refer to other documents, which will be of use in completing certain aspects of the subject. The document I am alluding to is entitled *The Consultative Draft Document for Updating the World Health Strategy. Geneva 1996.*

I think this is a key document, since, though it is not conclusive, it does involve the foundations for consulting all nations according to which the

health plan for the next century, for the year 2000, is to be drawn up.

I shall cite only the topics which I feel are important for the points we are investigating—the demands of health and morality. The WHO's definition of health, which we mentioned previously and which was stated at the Alma-Ata Assembly (1978), is assumed.

A) The Health Situation in the World

The document begins by stating that there have been very significant advances in health matters in the contemporary world, but that there are major deficiencies which need to be corrected. Democratic regimes are not found everywhere; three billion people are living in a state of poverty; the abyss between rich and poor is increasing; we are feeling the impact of population growth, a rapid rate of urbanization, migrations, aging, changes in climate, the thinning out of the ozone layer, air and water pollution, shifts in the distribution of public and private health care, decentralization,[8] low rates of infant mortality, higher life expectancy, a reduction of infectious diseases to only one billion people in the world population, an increase in nontransmissible illnesses, AIDS and nicotinism as the greatest causes of death,[9] and effective, low-cost technologies opening up possibilities for helping those who are least protected.[10]

B) The Demand of Health

The exigency of health care is to act in such fashion that the world's peoples can arrive at a degree of health which will enable them to lead a social, economically productive life in keeping with the world's environment, while respecting the values of the past, adapting to current changes and needs, and proposing solutions for the future. Their foundation must be equality in human rights.[11]

C) Practical Objectives and Principles

Their aims will be to improve life expectancy, quality of life, the health prospects of present and future generations, and reduce morbidity connected with aging.[12]

The main practices to achieve these goals are the following: worldwide action to protect health on a national and local level; developing a policy involving a scientific, factual approach which will be completed by people's participation in decision-making; a commitment to health strategies compatible with "sustainable growth"; applying a global focus on the life of the individual and health progress; a commitment to respecting the specific characteristics of each sex and to promoting quality of life; applying flexible strategies adapted to ongoing change; and considering cost-effectiveness.[13]

D) Strategy

A new strategy is required, the basic condition for which is its adaptation to the diversity of local values and cultural norms.[14] This strategy—whose principles contributing to health are to reduce the incidence and prevalence of disease—must combat the physical and psychic damage caused by morbidity. The framework for action will be based on the principle proposed within the UN—"sustainable growth"—with the human being at its center.[15] It will be necessary to promote macroeconomic and social policies based on equity, "by directly investing in health action with demonstrated cost-effectiveness, centered on unprotected groups and, in addition, introducing security factors aimed at protecting vulnerable populations."[16]

As for health systems and services, there will be provision for decentralization and solidarity between rich and poor, the sick and the healthy, and the old and the young.[17]

E) The Renewal of Demands

Some of the eight primary services stressed in Alma-Ata in 1978 will be updated. For example, "maternal and infant health *will be broadened and restructured* to include reproductive health." The area of essential medicines will be expanded to health technologies; that of transmissible diseases will be extended to nontransmissible ones, sanitary conditions for food, and food programs.[18]

As regards health technology, it must expand into biotechnology, food, medicines, telecommunications and information systems, and environmental technology, in terms of cost effectiveness for unprotected groups, with greater emphasis on quality.[19] As for human resources in health care, they must be updated through courses for health professionals as well.[20] Values and principles for action must translate into a fight against economic inequality as reflected in reduced medical assistance; priority must be given to the countries most affected by poverty and disease.[21] Specific characteristics linked to sex must be considered for more precise policy, in keeping with age, sex, and region, with a scientific, factual approach to improve cost-effectiveness and benefit the poorest groups in all countries.[22]

F) The New Health Paradigm

The new health paradigm seems to depend on two factors: 1) the availability of economic resources and 2) the probability of success. It thus depends on a choice of priorities. It is absurd to save a child from poliomyelitis if he is going to die the following year of malaria. Priorities are set because of a lack of economic resources. Specifically, they are set by those who provide WHO with economic means. We are far removed from offering individuals the best health care to the detriment of public attention to health directed towards what benefits

the whole community. The new paradigm involves a vision of the world where health is at the core of development and quality of life. Its goal is a dynamic, harmonious balance between health as an object of consumption and as an object of investment.

The most pressing areas for application of WHO resources are the following: infectious diseases, reproductive health, environmental health, nutrition, vaccination, essential medicines, health systems, noninfectious diseases, and substance abuse. Though the term "paradigm" later ceased to be used—since it was said to sound rather "esoteric"—it amounts to what is today associated with the new ethic for equality, solidarity, and health.[23]

G) The Spiritual Dimension

According to the document entitled "A Global Strategy of Health for All in the Year 2000," the WHO program also included the spiritual dimension, defined as a "phenomenon whose nature is not material, but which belongs to the set of ideas arising in the minds of human beings, particularly ennobling ideas." This new health approach—the document goes on to say—"has been influenced by certain human qualities, such as a sense of decency, empathy with the underprivileged in the health field, compassion, and a desire for social justice." "Nonmaterial values lead to a decision with significant material values for people anywhere who are capable of working productively and thus contributing to their own economic development and to that of the community and country in which they live."

H) WHO: The World's Conscience

In keeping with the foregoing, what should WHO's role be and that of its partners? WHO replies in the same[24] document: "To be the conscience of the world in health matters, foresee and analyze health problems in the world, provide strategic orientations for health development, and choose areas for technical cooperation in consultation with its partners. These priorities focus on *sustainable growth* in human and institutional resources to benefit less favored groups...." "Early detection of future health problems, especially within unprotected groups," will also be involved.[25]

I) Education

For all these purposes WHO has joined with UNESCO, for, if the schoolteacher does not educate regarding health, WHO programs will not be successful. The health program in the WHO-UNESCO link centers on reproductive health as a prime concern. Courses have already been created. In November 1996 a course was imparted in Costa Rica for Latin American teachers, and eighteen countries took part.

J) Ethics and WHO

The question now concerns ethics: Is ethics a part of WHO's health focus?

A Conference was held at WHO in collaboration with the International Council for Medical Science, March 12-14, 1997, on "Ethics, Equity, and Renewing WHO's Strategy Regarding 'Health for All in the Twenty-First Century.'" This Conference aimed to implement the right of all to health, create conditions to guarantee equity and access to essential health care, and improve prospects for quality of life. It was stated that to reach these goals it was necessary to make ethical concerns the core of WHO's programs; these concerns were seen to be ethics itself, equity, human rights, and health quality.

To comprehend what was affirmed at this conference, the ethical reflection conducted in Geneva, November 20-22, 1995, is essential. WHO invited a group of experts to discuss the subject "Ethical Consultation and Health on a Global Level." The main conclusions of the meeting were the following.

Ethics has meaning only when it translates into action. Traditional ethical orientations, such as the Hippocratic Oath, cannot completely serve as a foundation for practices and responsibilities which have changed. The new ethical debate is necessarily global. Ethical analysis concerns collective logic, not only the attitudes of individuals. Ethical debate must involve critical reflection on the notion of progress. The value and significance of health indicators must be questioned. The plurality of viewpoints must be recognized; but we can agree on what to do, without needing to agree on the reasons for doing so. In the new ethical debate each has a right to express his or her view, which must be listened to and evaluated. The criterion will not be consensus, but a search for convergence. The primary ethical value is honesty—e.g., in the case of pressure exerted by those supporting given programs, as with family planning in countries where there is resistance to it and those proposing it are seen as intruders. There are very few universal values. Multiculturalism forces us to reach an agreement to live together, both nationally and internationally. Ethics is not a list of values, but handling the contradictions arising among them. Equity is another ethical and political priority. Health must not be presented exclusively as a means to achieve greater productivity.[26]

The questions at the core of the debate were the following. Who is speaking on behalf of whom? Who has the right to judge? To judge what? Who defines the criteria for judgment?[27]

III. SOME IDEAS TO HELP US EVALUATE

A) Skepticism

For this group of experts dealing with ethics at WHO,

the conclusions appear to have involved utter subjectivistic skepticism—let each think as he pleases—since, though they define some principles, they later contradict them in the end by saying that no one can speak about anything with such moral authority as to warrant the following of his view; at most, contrasts may be smoothed over so as to live in a multicultural situation. And if there is no objectivity, no objective truth, everything collapses; if transcendence is not accepted, man's truth falls necessarily, and any ethic is impossible. Once more we see that ethics is situated in metaphysics, in the final and exemplary cause. If this formulation does not work, we then return to another kind of social pact where, on the level of ideas, we are all at war with each other, and, in order to survive, we agree not to attack one another and do something in common, even if we fail to see the reasons for doing so. To judge the WHO conception in the light of Christian doctrine, it suffices to recall what was said in the first part about the meaning of health in Christ the Lord.

B) Dialogue

Another matter is for us to attempt to judge what WHO says about health and the exigencies of health. We dealt with health, as defined by WHO, at the beginning of our remarks; as for its demands, we can see that care is shown for language and certain terms are used which may even be interpreted positivelyÄÄfrom a Christian standpoint as well. We think that everything, or nearly everything, which WHO states may be accepted because it may receive a correct Christian interpretation. Another point is that, in practice, certain aspects do not in fact allow for this interpretation, but are applied in a way utterly opposed to Christian ethics. I shall refer in summary fashion to two points: reproductive health and sustainable growth.

C) Reproductive Health

By this term WHO understands "a state of physical, mental, and social well-being of the human person in regard to sex and its functions." It is not limited to the absence of illnesses; reproductive health is defined as a constellation of methods, techniques, and services which contribute to reproductive health itself and well-being, anticipating and resolving health problems. It also includes sexual health, whose purpose is the enhance-

ment of life and personal relationships, and not just the counsel and care connected with sexually transmitted diseases.

In the Beigin document, no. 95, it is stated that "reproductive rights encompass certain human rights already recognized in international law, in the international documents on human rights. These rights include the basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to act in this way and to reach the highest degree of sexual and reproductive health.

It thus states in no. 94 that "reproductive health means that people can have a satisfactory and safe sexual life and the capacity to reproduce and to decide whether and when to do so. Implied in this condition is the right of men and women to be informed and have access according to their preference to safe, effective, accessible, and acceptable methods for family planning, along with other methods they may choose for birth control which are not against the law. 96. "The human rights of women include the right to control and freely and responsibly decide in matters related to their sexuality, such as sexual and reproductive health, free from coercion, discrimination, and violence. 97. "Women's ability to control their own fertility is a major basis for enjoying other rights. 93. "Counseling and access to information and reproductive health services for teenagers is still inadequate or completely lacking, and a teenager's right to privacy, confidentiality, and informed and conscious consent is often not taken into account It is said to be a right of the individual and the couple.

Observations

Behind these statements the door is left open to understanding reproductive health as a check on population growth, which is presented as the great evil to be avoided, with evidence acceptance of recourse to abortion and contraceptives.

There is no mention of marriage or the family, but of the couple and the individual, enabling whoever so desires to include homosexuality and lesbianism herein. It is a sample of how people proceed in the "new ethics," bringing contradictions into agreement so that all may think as they please while acting in a single direction so as "to be able to live together nationally and internationally."

On May 8, 1997, while representing the Holy See at WHO, I said the following: "As regards *reproductive health*, my Delegation would like to stress that this program directly concerns man's life

and may not be restricted to a stage of human existence. Man is a whole, with his physical, psychic, emotional, and relational dimensions. Consequently, conception, coming into the world, and sexual relations form part of a totality which commits the person to a relational dynamic involving both the family and society. Health linked only to the sexual and reproductive function would be a reduction and to some degree contradict the very definition of health which has been provided by WHO—that is, *a state of physical, psychic, and social well-being for the individual*.

D) Sustainable Growth

Another point drawing our attention because it is so often repeated is the reference to *sustainable growth*. At the UN General Assembly, on October 24, 1995, it was stated in this regard that "economic development, social development, and environmental protection are interdependent and form part of *sustainable growth*, reinforcing it jointly." This would seem quite correct; and yet, according to the interpretation of some groups at the UN, things are heading in another direction.

E) The Earth Charter

At the UN we encounter the so-called *Earth Charter*. In it there is reference to a new spirituality. There is mention of a network, a web of life, wherein we all exist. The goal is respect for the environment. The earth is divine: everything has a spirit—stones, trees, the rainbow, and so on. Man must submit to the earth; the individual's health is encompassed in the health of the earth. All religions must draw from their content that which strengthens relations with the earth so as to respect it more. The earth is divine—it is Mother Earth. Together with the Creator God, it is the divine female principle from which everything flows. This is the meaning of *sustainable growth*.

This is the new religion proposed at the UN. It is a pantheism with elements taken particularly from Taoism, Buddhism, and the ancestral religion of the American Indians, with priority given to the latter. It individualizes the earth as a living subject on which we depend. The earth has rights and needs and prescribes norms. Among those supporting this approach a group called GAIA and another called "The Carers of Wisdom" are prominent. The content of the *Earth Charter* is to

be the object of a campaign in civil society for a new "soft international law," if it is approved by consensus at the UN General Assembly in June 1997. The *Earth Charter*—particularly as regards *sustainable growth*—is proposed as the new version of the human rights cited by the UN in 1948. It is to be the new code for conduct, transformed into the principles of international law. At the outset, the Burtland Commission, which initiated this conception, had twenty-two norms; it is now stated that clear, concise charter should be drafted so as to obtain general approval by all UN members. It is to set forth the "moral imperatives and practical guidelines for *sustainable growth*."

About 4000 NGOs supported the postulates of this charter in Rio de Janeiro in 1992, but the time was not ripe, it is said, for intergovernmental agreement. The time is now thought to have come. There are three organizations strongly supporting it: the so-called *Council of the Earth*, chaired by Maurice Strong; the *International Green Cross*, chaired by Mikhail Gorbachev; and the government of Holland, led by Prime Minister Lubbers. The aim of the Council of the Earth, they say, is a "transition to a new path to development which will be sustainable in environmental, human, and economic terms," "a new global alliance which will embrace rich and poor, based on fundamental changes in economic conduct and relations."

Observations

As we can realize, to link *sustainable growth* to ecology is quite proper, but what is not is to divinize the earth and go right to the opposite pole of Genesis: instead of dominating the earth, we let ourselves be dominated by it. Christian dominion over the earth is humane and rational—clearly not the destruction of it. It is to guide the "habitat" as a prolongation of man himself, with all the cultural humanization which this requires and entails; it is completely opposed to the destruction and degradation of the ecosystem. It is to develop the vestiges and traces of God so that man will be a clearer image of Him.

As regards this sustainable growth, at the aforementioned WHO General Assembly, in the talk I mentioned previously, I stated, "If integral human development becomes the strategic framework for the new WHO policy, this means that the human person will be its end and measure; to reaffirm respect for his dignity and his right to life and quality health care and to recall nations' right and obligation to cooperate and show solidarity based on this respect and the

responsibility of each and every one constitute the best moral guarantee for a health policy in keeping with the original mission of WHO, with a view towards the third millennium.

F) Strategies at the UN

As we mentioned previously, all of these directions in thought are not, for the time being, the official conception of the UN, but of groups of people—particularly the NGOs present in the world body. At the general meetings of the assemblies they sometimes make their views prevail because their members appear with better preparation and more abundant financial resources than many of the countries represented there. The nations with the biggest say are the United States, Canada, Japan, and the European countries, especially the Nordic community; whereas the other nations bring small delegations, the former attend in large numbers and with significant resources; whereas the other nations virtually limit themselves to putting in an appearance and do not engage intensively in discussion, the former do so and cause their views to hold sway at the UN.

As regards the Holy See, there has already been a request at the UN that its legal status as a Permanent Observer be revoked, because, it is affirmed, the Holy See "acts at the United Nations to promulgate religious views"; "over and over again," the request continues, "we have seen evidence of the inappropriateness and negative effects of allowing the Holy See to use the United Nations system to advance the theological positions of the Catholic Church."[28] This is not, however, the official stance, as I have recently verified at the UN's WHO. I encountered understanding people open to dialogue.

By Way of Conclusion

Consequently, the positions we come across at the UN in regard to the demands of health and ethics are statements which can be given diverse interpretations and which thus leave room for dialogue.

Since the texts must remain open to multiculturalism, it is necessary for one to maintain a presence in the body so as to convey a Christian view and enable it to be recognized in the world as a valid position also capable of entering into dialogue. Let us not forget that, while setting aside all triumphalism, the Catholic faith is embraced by a fifth of the world's population, and, therefore, if only from a quantitative standpoint, it has a right to be heard and evaluated at least as a valid option. This fact was indeed accepted by the expert commission on ethics, to which we referred previously.

From the Vatican,
May 15, 1997.

+ JAVIER LOZANO BARRAGAN
President of the Pontifical Council for Pastoral Assistance to Health Care Workers

Notes

[1] G. DAVANZO, "Cuidado de la salud," *Diccionario enciclopédico de teología moral* (Madrid, 1974), 978-991.
[2] Cf. F.J. ELIZARI *et al*., *Praxis cristiana 2. Opción por la vida y el amor* (Madrid, 1981), 171-196.
[3] Cf. DIEGO GARCIA GUILLÉN, "La ética y la calidad de vida," in *CELAM: Biogenética* (Bogotá, 1992), 209-228).
[4] The Hospital Commission of the European Economic Community, May 6-9, 1979.
[5] Cf. ELIZARI *et al*., *ibid*..
[6] E. TELFER, "Justice, Welfare, and Health Care," *JournMedEth*, 2(1976), 107-111.
[7] Cf. F.J. ELIZARI *et al*., *ibid.*
[8] II,4.
[9] II,5.
[10] II,6.
[11] II,8-9.
[12] II,10.
[13] II,11.
[14] II,12.
[15] II,13.
[16] II,14.
[17] II,16.
[18] II,17.
[19] II,18.
[20] II,19.
[21] II,20.
[22] II,22-23.
[23] Cf. Margarita A. Peeter, *La Conferencia del Cairo y la OMS.*
[24] II,25.
[25] II,27.
[26] The current Director General of WHO, Dr. Nakajima, has stated that in the future the ethics arising from a monotheistic conception will not be applicable.
[27] Cf. Mazrgarita A. Peeter, "Nuevo debate sobre ética de la salud en la OMS, consulta ética y salud a nivel global," August 30-September 1, 1995, Geneva, *Report*, February 27, 1996.
[28] Document of the IPPF.

Testimony

The Non-Profit Nature
of Catholic Health Care

The Health Apostolate
in Ecuador

The Health Ministry
in the Italian Church

The Non-Profit Nature of Catholic Health Care Ministry

Joining the National Coalition on Catholic Health Care Ministry, the Ad Hoc Committee on Health Care Issues and the Church "affirms that our Church's health ministry continues the healing mission of Jesus. Called to be a sign of God's unconditional love for all, especially the poor and the vulnerable, this ministry is one of the most significant services which the Church offers to society. We likewise affirm that health care is fundamentally different from most goods and services and is consequently best delivered in a setting where human and community need are the primary concerns.

"Accordingly, we believe that ownership arrangements between Catholic health ministry organizations and publicly traded, investor-owned hospital chains compromise the Church's mission to an unacceptable degree. The primary motivation of publicly traded, investor-owned hospital chains is to provide a return to shareholders. The first commitment of our ministry is to render service to all in the name of Jesus.

"In that context, because health care is so integral to the Church's healing ministry, we strongly urge that as partnership arrangements are being explored, priority be given to those involving Catholic health care providers.

"The National Coalition pledges its resources to the future of Catholic health care and the Church's health ministry in the 21st century."

Ad Hoc Committee on Health Care Issues and the Church

APRIL 11, 1997

Your Eminence/ Excellency:

Following the recommendation contained in a varium assigned to the Ad Hoc Committee on Health Care Issues and the Church by the Administrative Committee and with its approval, the Committee now forwards to you the statement *The Non-Profit Nature of Catholic Health Care Ministry.* This statement is intended to reaffirm the fundamental truth about the nature of the Catholic health care apostolate.

Guided by the teaching of Pope John Paul II that there are some goods which by their very nature cannot be mere commodities, the statement was originally drafted by the National Coalition on Catholic Health Care Ministry, which released it in response to concerns regarding the appropriateness of the conversion of Catholic health care from a not-for-profit status to that of a publicly traded investor owned for-profit entity. The Coalition comprises the bishop-members of the Ad Hoc Committee and representatives from the Association of Catholic Health Science Centers, Catholic Charities USA, the Catholic Health Association, the Conference of Major Superiors of Religious Men, the Council of Major Superiors of Women Religious, and the Leadership Conference of Women Religious.

It is our steadfast prayer that the Catholic health care apostolate will remain a sanctuary in the rapidly changing environment of health care.

Fraternally in Christ,

+ (Most Reverend) DONALD W. WUERL
Bishop of Pittsburgh
Chairman
Ad Hoc Committee on Health Care Issues & the Church

Basic Document for Shaping the Health Apostolate

THE ECUADORIAN BISHOPS' CONFERENCE

Precedents

The Ecuadorian Church feels concern and anguish over the growing impoverishment of Ecuadorians and its impact on health.

Reality

1. Profound changes in current society and particularly in health care.

2. Scientific achievements and technological advances, with their ethical and moral implications, and socioeconomic and political events.

3. A context of social injustice, marked by lack of concern for social expenditures and violence, death, killings, ecological damage, serious nutritional problems, maternal and infant mortality, and endemic disease—all of which lead to pain and suffering among the poor.

4. Human suffering and pain do not affect people only physically, but have repercussions on their integrity as persons and in the family and community. Suffering is a human problem.

5. Natural and ecological disasters.

6. Deterioration and insufficiency of health services.

7. Poor application of resources, with 80% devoted to tertiary care and 5% to primary care.

8. Dehumanizing factors.

9. Illiteracy and underemployment.

10. A lack of orientation among those engaged in the Church's mission in the health apostolate.

11. A lack of coordination between the Church's health facilities and those of the Public Health Ministry, with the duplication of services.

12. A lack of access to health facilities because of distance and for cultural and economic reasons.

13. Distorted health information or an absence thereof.

Observations

1. It is necessary to draw up a unified project for the health apostolate with the collaboration of all Christians working in this field.

2. Action to defend life and health must be focused not only in terms of immediate needs of individuals and groups, but by developing projects in a framework of equity, solidarity, justice, democracy, the quality of life, and citizen participation.

3. Health professionals must maintain a willingness to listen and to search so as to support projects for improvement and act pastorally with effectiveness and realism.

4. New responses are needed from the Church community for effective service to the men and women to whom it is intimately united (*Gaudium et Spes*).

5. The Church must offer her specific contribution and commit herself to bearing witness, first recovering human dignity and then laying the foundations for the way of the Church (*Redemptor Hominis*).

6. Suffering man must be the object of concern and care in the Church's missionary action.

7. The commitment and witness of many lay people and the suffering of groups engaged in health care are a sign of hope and a challenge for the Church and the health apostolate in training and preparing human beings.

8. The health apostolate must remain open to and value contributions by psychosocial sciences and medical research, determine their groundedness, and focus its own response with the Word of God and the Magisterium on a national, diocesan, and parish level.

9. There must be coordination with the overall pastoral guidelines for the Church's evangelizing action.

Challenges

* Health is a basic right to which every person should have access, beyond all privileges and exclusions, and a personal duty which may not be evaded under any pretext.
* Health is an essential condition for personal and collective development.
* The training of health workers.
* Making health professionals sensitive to humanization.
* Creating awareness in society of each person's share in health.
* Forming diocesan commissions with decision-making autonomy in their jurisdiction.
* Seeking funds so that projects will become sustainable.
* Working preferentially with the poor and marginalized.
* The Church helps each community to recover its medicinal values.
* Health must be an area for evangelization.
* Base communities must take up their responsibility.
* Primary care to arrive at

"health for all in the year 2000," in terms of epidemiology, prevention, and attention to mothers and children.

* Coordination of the Church with the Public Health Ministry and the university to seek unified policies.

* Establishing agreements among Church dispensaries to work together in prevention in parishes.

We Christians must take action to defend life and health. Health is the affirmation of life and as such involves subjectivity, spirituality, living together democratically, the culture of recognizing what is different, the culture of joy and celebration, communion with nature, and a relationship to the earth as the mother of life and as the home and environment for all beings.

A dynamic and socioecological conception of health enables us to understand not only the physical causes of illness, but also the social causes. This helps us to dialogue and reach agreement between civil society and the Church and to improve the country's health situation.

Theological Grounding

To look at reality in the light of the Gospel enables us to discover the signs of life and death revealing themselves in our daily practice and challenging us to define ourselves as generators of life or death.

The word of the Lord makes itself heard through the suffering faces of men and women. It tells us they are hungry and thirsty and sick and calls us to commit ourselves to caring for life and health.

In this faith perspective we discover that the Church's commitment and solidarity in affirming life is a sign of the saving and liberating action of God in history.

* Genesis 1:2-6
* Genesis 3:8
* Deuteronomy 30:19
* Philippians 2:6; 8:16
* Matthew 4:23-25,31; 10:7-8
* Mark 2:1-11; 5:24-34; 16:18
* Isaiah 61:1-2; 9:1-2; 5:12-26;50:4-11
* Luke 4:16-21; 9:1-2; 5:12-26; 6:6-11; 7:36-50; 8:43-48; 13:10-17; 17:11-19; 18:35-43; 22:2; 23:2
* John 4:46-54; 6:54-63; 9:1-41; 10:10
* Acts 3:1-11
* Revelation 21:1-5

Theological-Biblical Grounding

* Care of life and health as God's saving and liberating action in each man.

* Everything was created by God for good and happiness, and man should enjoy, transform, communicate, care for, defend, and convey life in freedom (Deuteronomy).

* The cross as a source of meaning and hope.

* Jesus' attitude towards those suffering to lift them up so they will feel worthy and useful to society.

* The prophetic mission: to announce and to denounce.

* Health is salvation: "He cured and healed integrally."

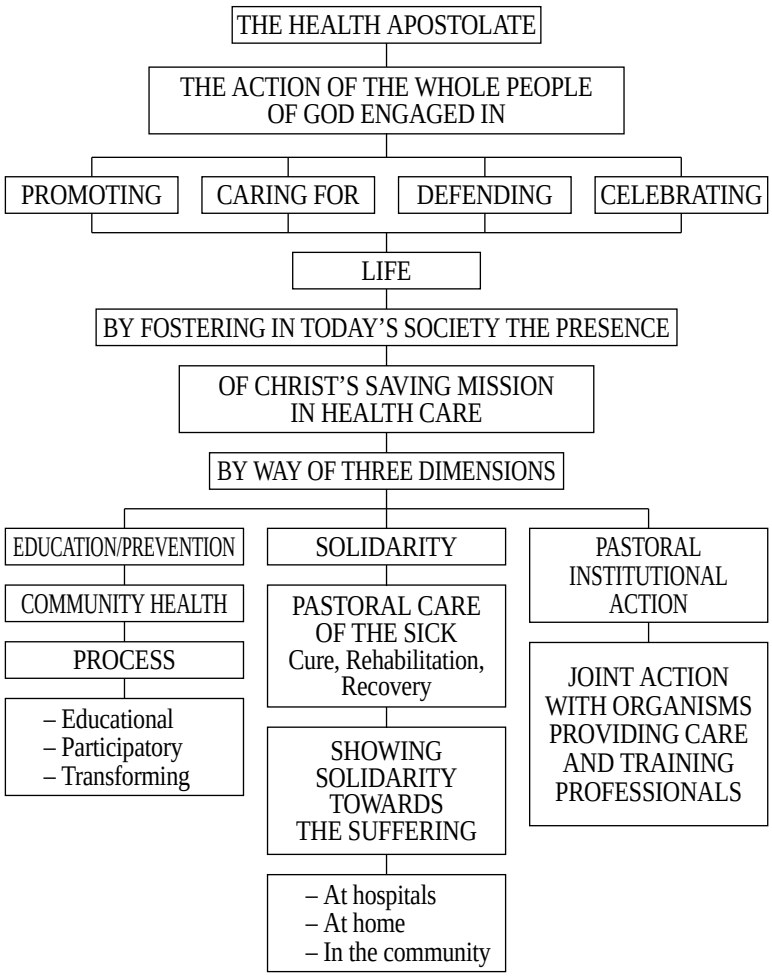
* To proclaim that the Kingdom of God is near: to cure the sick.

* The spirit of the Good Samaritan involves curing.

* Service to health is a mission, a call, a sending.

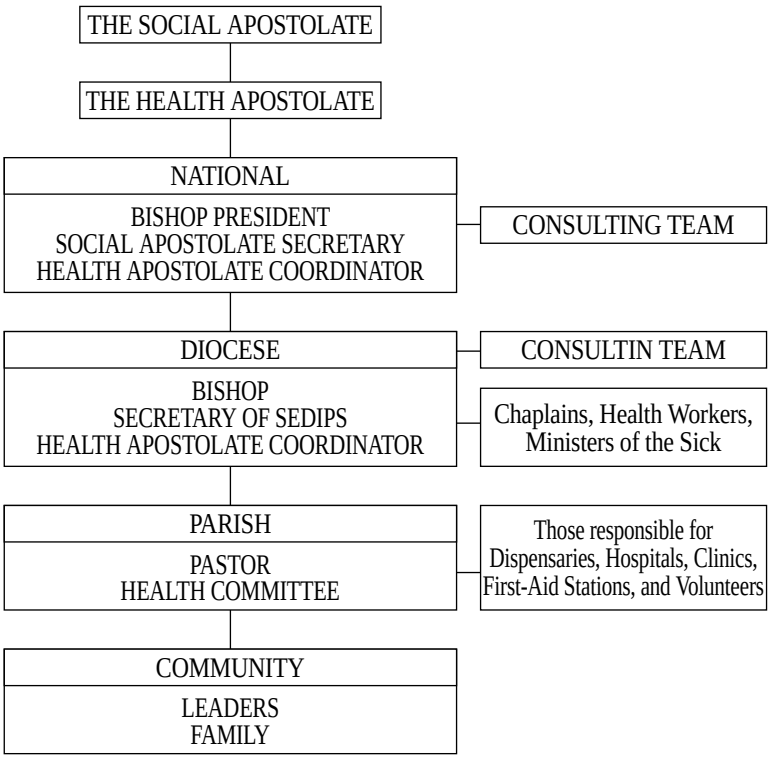
* Jesus announces the Kingdom with gestures and words. The poor and forgotten are leading actors in the Kingdom—subjects and evangelizers.

* "Seek first the Kingdom of God" (Matthew 6:33; 7:7 and John 8:31; 11:25). "Seek and you shall find." "Knock and it shall be opened to you." "Whoever believes in Me has eternal life." We are the children of light and truth, generators of life, truth, and light.



The health apostolate is called to robe all the Church's pastoral action in hope. —John Paul II

ORGANIZATION CHART FOR THE HEALTH APOSTOLATE



THE HEALTH APOSTOLATE

General Objective

To evangelize the world of health in a renewed missionary spirit, with a preferential option for the poor and sick, by taking part in building a just and solidary society to serve life.

Guidelines for Action

* The Community Health Apostolate
* The Pastoral Care of the Sick
* The Institutional Health Ministry

I. THE COMMUNITY HEALTH APOSTOLATE

General Objective

To motivate an educational, preventive, participatory, and transforming process in the community to improve the quality of life.

1. Specific Short-Range Objectives

1.1. To structure and organize the Health Apostolate Department in each Diocese

Strategy

To meet with diocesan authorities.

Activities

a) Communication and information—in contact with national, diocesan, and parish authorities—on the progress of the project.

b) To study the project with the diocesan secretaries and health coordinators.

c) To organize diocesan health commissions, with attention to creating regions and sectors and naming of directors and coordinators.

1.2. To evaluate the health situation in each diocese and seek alternative solutions

Strategy

To analyze national, diocesan, and parish situations with diocesan secretaries and pastors.

Activities

a) To exchange information on the health situation in each diocese and make an inventory of all available physical, psychosocial, economic, and spiritual resources.

b) To work out programs for prevention and promoting health and/or to support already existing programs, projects, and organizations.

c) To compile all the Public Health Ministry and NGO research on these subjects.

1.3. To plan, coordinate, and evaluate prevention and health promotion programs in each Diocese

Strategy

Meetings to plan programs on the diocesan, parish, and national levels.

Activities

a) To work out prevention, health promotion, and recovery programs for individuals, families, and communities.

b) To organize health education programs at health facilities and dispensaries.

c) To train workers for the health apostolate.

d) To involve health professionals and other human resources in the tasks of education and prevention.

e) To evaluate the progress and results of programs.

2. Specific Medium-Range Objectives

2.1. To deepen community awareness of the right to life and the obligation to work to achieve more humane living conditions

Strategy

Training and mobilization of health workers to promote active involvement to defend life in the community.

Activities

a) To train community workers to multiply results on a family and local level.

b) To review and update health care in the parish and make an inventory of physical, psychosocial, economic,

and spiritual resources (in regard to the right to life).

c) To systematize information and disseminate it at the national, diocesan, and local levels.

d) To make use of resources and popular wisdom.

e) To defend ecological health and denounce what undermines life and human dignity.

f) To evaluate the impact of the community health program.

3. Specific Long-Range Objectives

3.1. To complete the announcement of the good news with activities, words, and gestures

Strategy

To form organized groups sensitive to the health apostolate with a Christian commitment.

Activities

a) To prepare methodologies and materials suited to initial and ongoing training.

b) To train workers as "multipliers" to evangelize health care who will be illuminated by the Gospel, the Church's social doctrine, and faith.

II. THE PASTORAL CARE OF THE SICK

General Objective

To evangelize the sick so as to transform the experience of pain and illness into a means of sanctification.

1. Specific Short-Range Objectives

1.1. To stimulate everyone connected with health care to show solidarity towards the suffering—the sick and their families—both at hospitals and in the community.

Strategy

Meetings with chaplains, pastoral workers, and volunteers (ministers of the sick) at hospitals and clinics to form groups for reflection and support.

Activities

a) To form groups committed to the pastoral care of the sick.

b) To work out a plan of action based on an institution's context and needs.

c) To train interdisciplinary teams in terms of proposed pastoral guidelines.

d) To seek out, organize, and coordinate volunteers.

e) To support, accompany,

and orient the sick and their families.

f) To create and update records on patients and volunteers.

2. Specific Middle-Range Objectives

To promote a life of prayer and reflection on the Word of God so as to share it with those suffering.

Strategy

To form groups reflecting on the Word of God so as to lead a life of prayer.

Activity

a) To train volunteers integrally and permanently for spiritual/emotional attention to patients and families.

b) To coordinate chaplains and existing hospital or parish teams.

c) To seek out and organize volunteers in Church groups.

e) To assist the sick spiritually and accompany family members.

3. Specific Long-Range Objectives

To coordinate parish health groups to continue care of the sick at home.

Strategy

Meetings to establish a connection between parish and hospital volunteers so as to continue to accompany the sick.

Activities

a) To support parish groups so they will be able to provide physical, psychological, and spiritual assistance in keeping with perceived needs.

b) To orient volunteers so that, by their own reflection, they can find appropriate responses for each situation.

c) To organize visits to the sick at hospitals and in the community.

d) To accompany families of the sick with a human and Christian approach.

e) To create a parish solidarity fund for economic aid, medicines, clothing, mobility, and so on.

f) To update the parish census of the sick and elderly.

g) To prepare and celebrate the Sacrament of the Sick on a community basis at the parish.

h) To organize groups of patients to share prayer and experiences offering mutual stimulus and help.

III. THE INSTITUTIONAL HEALTH MINISTRY

General Objective

To work with organisms and institutions providing care and training professionals so as to foster more humane and integral attention to the sick person.

1. Specific Short-Range Objectives

To identify the persons with a Christian commitment at an institution.

Strategy
To establish contacts with the people manifesting a professional and Christian commitment at a health facility.

Activities
a) To contact the director of the hospital or clinic.
b) To contact the chaplain.
c) To study the reality of the health facility.
d) To form a team committed to humanizing patient care.
e) To request approval by the director of the hospital or clinic.
f) To seek out and support already existing groups.
g) To provide integral training of the health professionals committed to improving the human, Christian, and ethical aspects of care.

2. Specific Medium-Range Objectives

To form teams for reflection on the implications of science, technology, and bioethics for patient care in the light of the Word of God.

Strategy
To hold periodic meetings with the health personnel committed to this ministry.

Activities
a) To prepare an agenda based on the facility's needs.
b) To prepare meetings, seminars, and workshops on science, technology, and bioethics with stress on humanity in care.
c) To contribute to health policies by study and proposals.
d) To motivate professionals in their social commitment to educate patients and families.
e) To recognize life as a gift of God and make a commitment to defending it.

3. Long-Range Objectives

To motivate administrative and service personnel concerning the importance of humanity in patient care.

Strategy
Meetings with administrators for training in fostering humane care.

Activities
a) To make use of the media to educate, inform, and motivate the community regarding health and the defense of life.
b) To organize the week of the sick (February 11) and celebrations for prayer, thanksgiving, and other purposes.
c) To provide pastoral and educational materials at health facilities.

Appendix A

The Health Apostolate
Parish
– Promotion and Human Training
– To Care for and Protect Pastoral Health
– Accompaniment of the Sick and Elderly
In faithfulness to the mission to advance the Kingdom of God.

Appendix B

Suggestions on How to Organize the Health Apostolate in the Parish

Objectives
To call the community to take part in volunteer work with the sick.
* To value the importance of teamwork.
* To reflect on the objectives and guidelines in the basic document to mold the health ministry.

Objectives of a Health Apostolate Group
* To collaborate in prevention and health promotion by supporting programs and organizations engaged in this work.
* To promote the integral training of pastoral workers in health.
* To sensitize and motivate the Christian community as regards concern for its sick and elderly.
* To make the Lord's love a presence among patients and their families at the hospital and at home.
* To train health promoters for prevention efforts and make them effective "multipliers."
* To train the community to develop basic health action: prevention, education, nutrition, and rehabilitation.

Steps in Forming a Health Apostolate Group
In this process we must consider the following.

1. Creating awareness.
Objective:
To motivate the community so that it will take part.
Activities:
* To conduct campaigns to motivate the Christian community by way of posters, fliers, messages, and door-to-door visits.
* To ask apostolic groups, religious communities, health facilities, schools, and other bodies and institutions working in health to commit themselves to care and health promotion.
* To take advantage of gatherings such as Masses, liturgical feasts, and other celebrations to identify parish leaders.

2. Objective: To form and organize the health apostolate group.

Activities:
* To hold a meeting for those interested which is attended by the pastor.

* To have a clear program with specific aims.
* To reflect on the following: the importance of the health apostolate in the parish and the group's identity, philosophy, aims, alternatives, and action.
* To identify the main areas for action.
* To form a leadership with concrete functions.

3. Objective: To draw up a plan for work.
Activities:
To divide the parish into sectors, create a team for each sector, and designate those responsible and their functions.

4. Objective: To make an appraisal of the real situation.
Activities: The teams for each sector must take responsibility for evaluation through home visits to establish the following points.
* The socioeconomic situation in each sector.
* The main health problems.
* Living conditions.
* Environment.
* Problems affecting health and illness.
* Problems connected with garbage disposal, pollution, drinking water, sewers, drug addiction, alcoholism, and disability.
* The make-up of families.
* Health institutions: facilities, hospitals, homes for the elderly, nurseries, centers for the disabled, etc.
* Other institutions: schools, community action, NGOs.

5. Objective: To conduct a census of the sick and elderly in the parish.
Activities:
* To form teams for solidarity, accompaniment, and education.
* To create records on the sick and elderly:
a) Name, age, address
b) Profession, job, tastes, skills
c) Kind of illness or invalidity: treatment, diet, and medical visits
d) Access to health services
e) Personal situation: how illness, invalidity, or old age is being faced by people (acceptance, rejection, depression, anguish, passivity).
f) Family situation: acceptance and love or neglect and marginalization.
g) Environmental conditions: state of the home, diet, hygiene, clothing, medicines.
h) Whether or not spiritual and religious needs are being met.

6. Objective: To form and train working groups.
Activities: Ongoing meetings for training, Bible courses, first aid, nutrition, psychology of the sick, hygiene, patient care, prevention of illness, and so on.

7. Objective: To program and evaluate activities.
Activities: Groups should meet every month, setting a date, hour, and location and preparing to program and evaluate activities.

These meetings should begin with a reading from the Bible and include consideration of documents, relevant news, and the sharing of experiences. This is the occasion for assimilating information.

Note: This outline is a suggestion for forming the health apostolate team. It may be modified or adapted as necessary.

Appendix C

The Demands of the Health Apostolate

1. This work is carried out on behalf of the Church and not individually.
2. It is a work of the Spirit: action and prayer in the name of the Lord Jesus.
3. It requires teamwork to ensure effective announcing and continuity.
4. It is organized, planned work. The health apostolate is
* an apostolate of life, not death;
* an apostolate for health, not illness;
* an apostolate by the whole People of God, not just the clergy;
* an apostolate for encounter and celebration, not a ritualistic and cold one;
* a missionary, evangelizing apostolate, not one that it sacramentalistic;
* a community apostolate not confined within the family alone;
* an apostolate of and with the sick, of evangelized and evangelizing persons.

Appendix D

Teamwork
Some Points to Consider

Interdisciplinary collaboration
Good interpersonal relations
Suitable places to meet
Clear objectives for unified criteria
Cooperation and the means to work
Communication and dialogue
Ongoing evaluation
Openness on the part of team members
Recognition of the skills and values of others
Organization and coordination
Responsibility and honesty
Stimulus and appreciation
Identification with work
Generosity
Professional jealousy and disloyal competitiveness harm teams.

Benefits
Personal and professional growth
Attainment of objectives
Effectiveness
Better use of time and the elements proposed by the Ecuadorian Bishops' Conference and advisers.

Appendix E

Profile of the Health Worker

I. The Vocation Is Innate or Acquired

It is a call, an option, and an identification with the institution where one works—you must not bite the hand that feeds you. Health workers must love life, and when they pass by, they communicate life because they are in love with life. In the hospital environment, where there is suffering, pain, and death, the worker must not have a deathly appearance, but must convey life. Health should be desired, loved, and respected by the health worker and be manifested in the joy of living. Generosity means being a co-worker—honest, responsible, and capable of not taking advantage.

II. Service

must be directed towards life, persons, the suffering. No payment can suffice; work must therefore be done as a mission. Service should be timely, appropriate, effective, of high quality, and empathetic in anticipating the needs of others. The best professional is the one with the biggest heart (love).

III. Professionalism

involves competence, skill, updating, ongoing training at all levels, teamwork and sharing of tasks and responsibilities to provide the best service. Professionalism appears in the way people act and includes the health team.

The Healthcare Ministry in the Italian Church

Introduction

Many years ago I met with the director of a large Canadian hospital to talk about the role of pastoral care at the facility managed by him. During that interesting exchange he repeated to me several times that action by the health ministry ought to follow the laws of marketing. Indeed, he felt that acceptance of what the Church offered largely depended on the way the Church was presented to people.

While preparing this paper, I recalled the suggestion by that hospital administrator. I thus prepared to do some good marketing. That concern quickly vanished, however, when I considered that you are those chiefly responsible for pastoral care in health. *De re vestra agitur*.

This appears clearly in a text by St. Charles Borromeo. In commenting on the parable of the Good Samaritan, the holy archbishop of Milan sees Christ represented in the Samaritan—Christ picking up the wounded man lying alongside the road, caring for him, and, after setting him upon his horse, taking him to the inn, a symbol of the Church. Christ entrusts him to the innkeeper, *who symbolizes the bishops*—the latter are to take care of him, and Christ gives them two coins, images of the Old and New Testaments, which are the keys to interpreting the mystery of human suffering.

Does the Council decree *Christus Dominus* not invite bishops to "surround the sick with paternal charity"? (*CD* 30).

On the basis of these introductory remarks, I would like first of all to review the road traveled by the Italian Bishops' Conference over the last thirty years in the area of the health ministry. After this overview of the situation in health policy and care, I shall move on to the evolution of the Church's presence and action in this significant field of human life and conclude with some practical orientations.

I. If we examine the pastoral programming drawn up by the Italian Bishops' Conference from the 1970s on, we can identify the place occupied therein by the healthcare ministry.[1]

In the period extending from 1970 to 1980, during which pastoral orientations focused on the relationship between *evangelization and the sacraments*, a document appeared on pastoral care in health: *Evangelization and the Sacraments of Penance and Anointing of the Sick* (1973).

The sixteen pages devoted to the sacraments and the ministry to the sick reflect the atmosphere of Vatican II and are supported by the new rite of Anointing; the published text is accompanied by a lengthy introduction with a pastoral focus (*The Sacrament of Anointing and the Pastoral Care of the Sick*, which became obligatory on February 16, 1975).

In the decade of the 1980s, focusing on *communion and community*, four significant documents were written. The first was the *Note* by the National Council on the Healthcare Ministry.[2] This is an important text summarizing the reflection of the Italian Church in this area after the Second Vatican Council. The second was the pastoral document by the Italian Episcopate on *Evangelization and the Culture of Human Life*, the concluding accomplishment among the different endeavors in pastoral and cultural action carried out by the Italian Bishops' Conference in 1988 and 1989 to mark the twentieth anniversary of the Encyclical *Humanae Vitae*.[3] This is a very beautiful text dealing with the subjects of suffering and death (nos. 33-35) and of chronic and incurable patients (no. 51) and including the innovative positions expressed by John Paul II in preceding documents (no. 59).[4] It was followed by *Pastoral Problems and Prospects of the Elderly Who Are Not Self-Sufficient* (June 6, 1989) and *Pastoral Orientations on Psychiatric Patients* (October 25, 1989).

In programming for the 1990s, devoted to *evangelization and the Gospel of charity*, two texts have been published which deal specifically with the healthcare ministry: the "Note on the Pastoral Implications of the Problem of Substance Abuse" (June 12, 1990) and "Pastoral Reflections on the Living Conditions of the Disabled" (February 2, 1991).[5]

While relevant, the material devoted specifically to the health ministry seems to be rather scanty if compared to all that papal teaching, particularly John Paul II, has offered to the universal Church. Let it suffice to recall *Salvifici Doloris*, the beautiful paragraphs in *Christifideles Laici* (nos. 52 and 53), the Motu Proprio *Dolentium Hominum*, whereby the Pope established the Pontifical Council for Pastoral Assistance to Health Care Workers, and, finally, the fourth chapter of the Encyclical *Evangelium Vitae*.

It would, however, not be fitting to restrict the concern of the Italian Bishops' Conference for the health apostolate exclusively to the documents cited above. Indeed, the path proposed by the Conference's ten-year programs is an orientation which all the members of the Church ought to apply to their respective fields. The

relation between evangelization and the sacraments, the essential importance of communion, and charity as a primary way to announce the Gospel are all subjects wherein health workers can and must find effective stimuli to renew their ministry.

Though this fact is recognized, it is only natural for those living and working in health care to ask why in their very beautiful documents on charity the Pastors of the Church speak so little about illness and health and charitable service to our brothers and sisters living through the difficult period of suffering. In the draft text preparatory to the 1995 Church Meeting in Palermo—*The Gospel of Charity for a New Society in Italy*—there is no reference to illness, death, hospitals, or health policy, at a time in history when the defects in public health administration occupy the forefront in the news breaking day by day.

As has been suggested, is it true that the *nocturnal dimension of life*—pain, illness, and death—causes so much fear, even among the bishops, that the latter, without realizing, refrain from devoting proper attention to it?[6]

The texts have been followed by certain measures, among which the establishment of the National Council for Pastoral Care in Health should be recalled.

Though definitively structured in 1978, this Church body, overseen by the Italian Bishops' Conference, started work in 1962 and was among the first, alongside the Catechetical and Emigrant Offices. At present the National Council is governed by three bishops from different geographical areas, one of whom serves as President. Designated by the Permanent Council of the Italian Bishops' Conference, the three Pastors guarantee an organic, direct relationship between the health ministry and all the pastoral activity of the Italian Church. In its structure, the National Council—now possessing a permanent office at Conference headquarters—comprises regional bodies (headed by a bishop), diocesan organisms, and representatives of all sectors of the People of God engaged in health care: religious orders at hospitals, chaplains, Catholic associations in the health field, both professional and voluntary, and different patients' groups.

Among the numerous significant activities by the National Council, we should recall the three national meetings—the first focusing on "The Local Church and the Health Apostolate" (1981); the second, on "The Health Ministry in the Community" (1981); and the third, on "Church Projects in Health Care"—as well as the abovementioned *Note*.[7]

Though there are disparities in their functioning, which is still inadequate in many places, no one can cast doubt upon the importance of these structures providing stimulus, on which the organic, orderly, and ongoing growth of the health apostolate depends, at least in part.

In dealing with the bishops' involvement in the health ministry, it is not possible, for obvious reasons, to dwell upon the steps taken by Pastors individually on a diocesan or regional level, which are numerous and varied. It is not easy, in fact, to obtain precise documentation on what is being accomplished in the local churches.[8]

II. What does today's health world look like, and, above all, what cultural atmosphere does it reflect?

To answer these questions, it would be good to start from a statement by Albert Camus. When speaking of health care, the French writer said that it is not doctors, but society which should be judged by the way people suffer and die therein. With these words, Camus meant that the behavior of health workers in care of the sick and dying was rooted first of all in the culture and politics of the society where they worked rather than in each of them personally.

Is this observation not an invitation to consider the world of health care in the broader context of the society and culture dominating it?

Secondly, in identifying the limits in service to the sick in our society, it is appropriate not to dwell excessively or exclusively upon the way it is described by the mass media. There is a certain coarseness in the news appearing in the press and on television—a coarseness which sometimes amounts to looking for scandal, without the objective criticism which is able to make distinctions, situating a single episode within a context.

The ideal attitude to take is to view health situations by placing them in the climate of ambivalence typical of our society which sometimes takes on shades of ambiguity and contradiction.

Here are some contrasts, then, documented by certain studies,[9] which help to understand the world we are living in.

* The atavistic problems of indigence are being resolved everywhere, *and yet* in consumer society situations of suffering and human incompleteness are on the increase.

* Ideologies are collapsing, *and yet* we sharply perceive that man is increasingly in danger in pragmatism, in a framework of massive deceleration of history which is not rationally governed or imbued with values.

* There is a growing tendency to draw back into the private sphere, understood in a selfish way, into "one's own business," *and yet* at the same time the need is spreading to reach out in active generosity towards those who are not very fortunate in life to make up for the many deficiencies afflicting them.

* Significant participatory experiences are collapsing, having been stripped of meaning by merely bureaucratic practices, *and yet* at the same time there is a massive unfolding of participation based not on mere control, but on taking up responsibility directly and seeking to respond personally and globally to people's needs.

* The idea is spreading that self-interest is the only measuring rod for constructing re-

lations with others, *and yet* the realization is also emerging that only in gratuitousness and self-donation is the person truly built up and deeply enriched.

If we move from a general context to the more specific one of health care, the contrasts present themselves as follows.

* From a social standpoint, we cannot ignore the progress made in protecting and defending the sick, ensuring the care they need for healing, and accompanying them in cases of chronic or terminal illness. The health reform decreed by Law 833 in 1978 represents a sign of great social and civil maturation. Who fails to recognize the value of Law 194? Progress in awareness of personal dignity is marked by the drafting of *charters for patients' rights*. *However*, the socializing of care has often become a standardization of services without humanity, a multiplication of facilities not based on the criteria of rationality and justice, and a mortification of the spontaneous initiative of institutions with a social vocation for the sake of partisan interests, whether political, economic, or related to unions.

* The manifest aim of medical technology is certainly humanistic.

Let it suffice to consider the chance to prolong life, relieve sufferings, and improve the quality of people's social functioning. The use of increasingly sophisticated equipment gives patients new alternatives, a greater opportunity for communication. The freedom of the person expands horizons.

If technology can be a modern way of spreading God's tenderness, it may, *however*, also lead to the fragmentation of man, to a separation from his life experience, and to neglect of the human meaning of his illness.

* If, on the one hand, turning hospitals into enterprises enables them to hold back expenses, *on the other*, it may lead administrators to take only costs, pure and simple, into account, forgetting that the person is not a machine.

* While immense, dogged efforts are made to prolong life and produce it artificially, those already conceived are *not* allowed to be born, and the death of those no longer deemed useful is accelerated.

* Whereas, on the one hand, health is rightly valued by multiplying steps to promote it, *on the other*, people go so far as to turn it into an absolute consumer value, bringing about a new marginalization of the disabled, the elderly, and the terminally ill.

* The urgent appeal to health personnel so that they will join an ability to form relations to technical expertise, acquiring a capacity for listening, respect, and empathy, often *contrasts* with the cultural climate of our time, where such attitudes are not seriously taken into consideration.

Let us quote a reflection by Moro, who observes the following.

"It cannot be surprising that in these situations there is, on the one hand, an increase in *exploitation* of man by man, a *collapse* of appreciation of those, too, who do not seem to meet predetermined standards for productive, perfect, modern man, and *loneliness* and marginalization of those seen as different; but also, *on the other*, renewed attention to those suffering and a commitment—*not an episodic one*—to seeking not only to relieve wounds, but also to remove the causes provoking so many deferred human abortions."[10]

If we fail to consider this ambivalent tendency, it is easy to fall into inappropriate attitudes to the world of health.

In the health reform years—for instance, at the Second National Meeting organized by the National Council—the Church community's desire to take part in society's efforts to establish socialized health care seemed evident, entailing greater participation by the population, with a concern for the needs of all, especially those least well off. Though that desire may not be said to have disappeared—and, in fact, it has not—it nonetheless seems clear that it has become weaker, nearly scuttled by the major difficulties in applying the reform law and by all the phenomena involving corrupt administration which have held center stage in recent news.

In addition, whoever closely examines the Church community's stance in the face of health care cannot fail to observe a certain bewilderment regarding its complexity, the result of major changes of a scientific, technical, cultural, religious, and ethical nature. This perplexity may readily prompt moralistic attitudes and simplistic condemnation of medical technology and the behavior of health workers. In many cases, the prevalence of emotivity and moralism leads people to see reality in partial terms, overlooking the global situation.

The following is stated in the National Council's *Note*.

"It is to this world of health that the Church, by virtue of her mission, is called to open herself, animated by hope, a spirit of cooperation, and the will to make an essential contribution to man's salvation" (no. 12).

These words indicate that the Church community is called to love this universe of health, "the crossroads of great hopes and great dramas affecting mankind—dramas involving injustice, violence, a lack of love, aberrant ethics, and sin"—but also a place where love and generosity achieve significant success. She is called to love it, allying herself with that part of it which is healthy and listening to its beating heart.

Is this not the most suitable way to fight for life's true values?

III. In moving on now to point out the evolution of the health apostolate in recent decades, I shall indicate some shifts which are already taking place, but are still far from being completed.

The First Shift: From the Sick to Health Care and the Environment Surrounding Patients

This shift was already discernible in the terminological

changes appearing after Vatican II. There was no longer talk of pastoral care for the sick or at the hospital, but, rather, of the health ministry, on the understanding, then, that Church action is called to deal with the whole problematic of man's psychophysical and spiritual reality and the environment in which he lives and works, especially the domain of the family.

Two biblical texts help us to comprehend this necessary shift from the sick to health.

The first is taken from the Book of Isaiah: *He has taken on our infirmities and borne our illnesses... Through his wounds we have been healed* (Is 53:11).

These words, applied by the Gospel to Christ (Mt 8:17), indicate that the Church perhaps needs to a greater extent what may be termed the *Marian* dimension—that is, the feminine dimension made up of "silent proximity in pain," of grandeur becoming acceptance and service in relation to the poor, the weak, and the victims of illness and death. Indeed, in the churches which sometimes display a façade characterized by power and success, denying with their appearance of comfort and self-confidence the bleeding body of their Lord, there is little room for receiving the sick and the suffering.[11]

The second text, to be applied to the Church community, is made up of the words of Jesus included by John: "I have come that they may have life and have it in abundance" (Jn 10:10).

A commitment to promote living conditions enabling people to realize themselves according to a scale of values which are authentically human and Christian should thus be joined to loving medication and binding up bodily and spiritual wounds.

The challenges posed by this broadening of the health ministry are of considerable scope.

They entail a renewed commitment to give life to the *new evangelization*—new in methods, ardor, and manifestations—which John Paul II invites us to carry out in all areas of human life and action.

Indeed, there have been major changes in the way health, suffering, birth, life, and death are conceived.

If we limit ourselves to health, the *Note* by the Italian Bishops' Conference affirms that health "does not refer only to physical and organic factors, but also involves the psychic and spiritual dimensions of the person, extending to the physical, emotional, social, and moral environment in which the person lives and works. A profound connection is observed among health, the quality of life, and human well-being" (no. 6).

To extend the health apostolate from a necessary *closeness to the sick* to the evangelization of culture regarding the different aspects of life first of all involves bringing the individual to the realization that life is not a problem to be resolved, but a mystery to be lived out, as Gabriel Marcel states.

In contemporary culture many stages of human life have lost their *mysterious* character. They have been deprived of the experience of the feelings of the *tremendum* and the *fascinosum*, about which Otto speaks. Interesting studies by Peter and Brigitte Berger and by Norbert Elias have demonstrated the attempt—typical of our culture—at enclosing the capital events of existence (birth and death) in the restricted and inauthentic horizon of everyday banality.

A further step to be taken consists of shaping a nonreductive vision of life, health, suffering, and death and educating people to grasp their deep meaning.

A lay journalist asserts that modern society has gradually turned itself into a victim of a choice with no apparent way out: either full health or death. In other words, we are no longer strong enough to endure the intermediate sufferings: either we are well enough to enjoy life or annihilation—euthanasia—is better.

The words addressed by John Paul II to a religious institute are significant.

"I exhort you to join the evangelization of health culture to irreplaceable closeness to the sick to bear witness to the Gospel vision of living, suffering, and dying. This is a basic task which must be carried out by the institutes for formation of your religious families..."[12]

Indeed, the world of health is one of the places where it is possible to observe with greater intensity the drama of ethical and spiritual conflicts associated with life at all stages. John Paul II asserts the following: "The new frontiers opened by the progress of science and its possible technical and therapeutic applications touch the most delicate spheres of life at its very sources and in its deepest meaning."[13]

To make evangelization truly reach the heart of man and, therefore, the cultural matrix of his decisions, it is thus necessary to enter into dialogue with present-day cultures of health, life, and death, making an impact on lifestyles, and to propose new cultural models inspired by the Gospel, not withdrawing from the forums where new cultures are generated. This dialogue is made up of understanding and respect, but also of confrontation.[14] This involves a capacity to accept what is positive in current culture and value it. At the Church meeting in Palermo, a representative of secular society invited stated, "My secular heart is restless as is your heart belonging to the Church."

There is no doubt that the evangelization of the world of health should not be effected from the hospital ward alone, but also from *teaching chairs*. Only recently has an awareness of the need to make an impact on culture through teaching and stimulus, too, been taken into serious consideration by those engaged in the healthcare ministry. Indeed, without adequate and ongoing training it is impossible to establish a dialogue not only "in the laboratories where the health culture is conceived and choices are made in this field, but also in everyday health work, where

it is gradually constructed and turned into behavior."[15]

Finally, there is the major task of education to harmonize the two leading forms of logic which too often dispute supremacy in all areas of life: technical logic and ethical logic. The former lets itself be guided by the principle of possibility; the latter, by values.

The clash between the two aforementioned logics is readily understandable if we consider that the process of secularization and secularism has fostered the shaping of a healthcare environment outside the Church and often opposed to the forms of charitable care directed by the Church for centuries. Medicine and social services based on biology and human behavioral sciences have certainly broadened their influence to the point of determining what appropriate human behavior ought to be. Is it not true that the professionals in these disciplines define and resolve the problems concerning the person at all levels, including that of ethics, becoming specialists in the areas of abortion, sterilization, and organ transplants?[16]

What style should be adopted in carrying out the new evangelization of health culture?

In the article two are specified: the prophetic attitude and cooperation. Both are necessary. All of us are familiar with the prophetic courage of John Paul II in denouncing attempts upon the life and dignity of the person. The abovementioned Encyclical *Evangelium Vitae* is eloquent proof of this fact.

Alongside denunciation, however, there is also cooperation, which may be implemented at different levels: teaching ethics, interdisciplinary study, taking part in ethics committees, and intervening in the drafting of laws or programs concerning health, ecology, and the care of the sick.

Is it not true that too often the Church limits herself to intervening to defend herself from unjust laws while remaining more idle when it comes to drawing up wholesome laws?

The Second Shift: From Offering Sacraments to Evangelization and Humanization

The reflection of the Italian Church after the Council has had a beneficial effect on the interrelation among the three functions of pastoral care: the Word, the Sacraments, and service.

We should note the relation between the program of the Italian Bishops' Conference at the start of the 1970s, *Evangelization and the Sacraments*, and the beginning of the

process of moving beyond so-called *sacramentalism*, which commenced in the hospital ministry at that time. Not only at hospitals, but also in parishes there was a realization that, though the state of illness and, above all, the proximity of death offered a favorable occasion for administering the sacraments, this action was, however, too often detached from a path of spiritual growth. Evangelization was not, in fact, on a par with the large-scale consumption of the sacraments.

The health apostolate was forcefully spurred to attribute greater value to service by the Church meeting held in Rome in 1976, devoted to human advancement. *Humanization*—that was a term which became fashionable at the time. This neologism refers to service under the aspect of struggling against all that offends the humanity of the sick and contrasts with the values inherent in their personal dignity.

In pastoral practice in recent decades osmosis has certainly occurred as regards announcement, the sacraments, and charitable service. The word, sacramental gestures, and charitable attitudes and works are not separated, but remain in constant intercommunication. Indeed, what is announced is God's loving plan for men; what is celebrated is God's love for men: the body broken, the blood shed; announcement and celebration stand in relation to fraternal love.

But are the degree and quality of this *osmosis* satisfactory?

We cannot ignore the fact that in pastoral literature there are still indices of a certain *sacramental obstinacy*. Do some circumstances at the present time in history not favor the reduction of pastoral care to the administration of the sacraments alone? We may consider the decrease in the number of chaplains, their resistance to specific training, and how hard they find it to involve deacons, religious, and lay people in pastoral service, among other things.

As regards humanization, I feel it has been successful only in promoting volunteer work and in training programs aimed at improving the human quality of relations with the sick. Many pastoral workers find it difficult to recognize the value for evangelization of humanity in care of the sick and at health facilities. For them I shall quote a fine text which also reflects the thought of Paul VI in *Evangelii Nuntiandi*.

"When care-related gestures are filled with charity, translating into generous dedication, a warm approach, marked sensitivity, and a humble, freely-offered presence, they possess a forceful inner vitality which transcends them: they pose irresistible questions (*EN* 21). They expand the areas of understanding and shared perception, constitute a kind of platform from which to set out for further goals, open men's minds and hearts to new horizons, and become a silent, but

very forceful and effective proclamation of the good news. They are the first form of evangelization."[17]

After hearing these words, how can we fail to appreciate the rightful value of the humane approach, dialogue, and the helping relationship?

In this regard, a deeper examination of reflection on the relation between salvation, understood as definitive communion with the Father, and the foretastes in history of this newness of life would thus be appropriate. Indeed, if salvation, as *Evangelii Nuntiandi* further states, is, above all, liberation from sin and the devil, in the joy of knowing God and of being known by Him, of seeing Him and abandoning oneself to Him, it is also "liberation from all that oppresses man."

The Third Shift: From the Hospital to the Community

The first national meeting of our Conference's Health Council was devoted to this topic, over ten years ago. This shift was also spurred by the 1978 Health Reform, which pointed to the need to move from health facilities to the community. Significant articles have dealt with this subject.[18] Can we state that the work done in this area has been meaningful? Though there are satisfying results in some fields, in others are lack of initiative is observable. In a number of parishes groups of visitors of the sick have become active. In many Church communities—especially after the Holy Father's initiative—sufficient importance is attached to the Day of the Sick. For numerous parishes community celebrations of the Sacrament of the Sick have become a tradition. Families, too, not only benefit more from community solidarity, but are also helped to take part more effectively in the process of treating their loved ones by assisting and accompanying them with love.

But what can we say about evangelization and catechetical instruction on topics related to health, illness, suffering, and death, about cooperation between hospital chaplains and parish priests, about the training of health workers who can be reached only in parishes, and about the involvement of Christians not only in voluntary care, but also in local organization and management of health care?

It is hard to answer these questions because we lack data. Is this because of an utter absence of data or because we lack the means for processing the data? Careful research, like the work done by *Caritas* on services provided in Italy, would be quite helpful.[19] It shows, for example, that many

of these services reflect a philosophy oriented more towards free care than towards prevention or social adaptation.

I shall conclude this section by stressing the importance of superseding the identification of the health apostolate with the hospital ministry. I recall the reaction of a young priest who attended a diocesan health ministry meeting a few years ago. At the end of the session he expressed his frustration because discussion had, as usual, focused on hospital problems.

The Fourth Shift: From a Passive Attitude (Leaving Responsibility in the Hands of Others) to an Attitude of Active Involvement

A new image of the Church arose from Vatican II, wherein it was understood to be an organically structured community in which all members enjoy the same dignity and are called to cooperate in a single mission, while following different modalities according to their specific vocations. Consequently, as the Italian Bishops' *Note* states, the primary subject of the health apostolate is the Christian community in all its members (no. 23).

We certainly cannot avoid a feeling of wonder at the wealth and variety of Church endeavors present in the world of health. If we limit ourselves only to those activities that are organized, there have been nearly 2000 hospital chaplains (accompanied by many pastoral workers, both religious and lay), 10,000 women religious and a few hundred men religious active in health care, 900 facilities serving health and the human person (420 hospitals and clinics, 150 rehabilitation centers, 100 institutions for home care, 180 facilities distributed among centers for the disabled or long-term patients and ambulatory services; 225 facilities are covered by ARIS), and associations made up of doctors, other health workers, volunteers, and patients. All the Church members who are active outside of organizational frameworks should also be added.

Two questions arise when we observe this complex panorama.

The first might be formulated as follows: In the Church community, as regards the world of health, who needs to be given more room for action? A close look at the present situation leads us to point to patients and women in this connection.

In the Apostolic Exhortation *Christifideles Laici*, John Paul II states that suffering man is an "active and responsible subject in the work of evangelization and salvation" (no. 54). This statement by the Pope shows a recognition of the charism of the suffering, of their creative contribution to the Church and the world: "The sick, too, are sent [by the Lord] into his vineyard as workers" (no. 53).

The importance of this shift from conceiving of the sick as the object of care to seeing

them as subjects responsible for the advancement of the Kingdom escapes no one. This change in perspective should be viewed in the light of the whole social and civil movement which has been manifested, in part, in the different *charters for patients' rights*. One of the main aspects considered in these documents is patients' right to be involved in their own treatment, thus playing a responsible role in the process of care affecting them personally.

How is this change in accent when viewing the sick possible?

The Italian Bishops' *Note* provides a very precise answer: "It will be difficult for the sick to assume their role as active subjects in the Church community unless they are first the 'aim of the Church's love and service' (*ChL* 54) and find human, spiritual, and moral support therein" (no. 26). Valuing the presence of the ill, their witness in the Church, and the specific contribution they can make to the salvation of the world requires a whole effort in education for love, not only at health facilities, through appropriate accompaniment, but also, in a special way, in parish communities, with recourse to a theology of suffering which, while will avoid falling into "pain-centeredness" and be able to communicate, as the *Note* states (no. 26), that even "life's negative events—including infirmity, disability, and death—are 'realities redeemed' by Christ and taken on by Him as an 'instrument for redemption'" (*SD* 26). The Italian Bishops' *Note* declares that "the Christian, through a lived sharing in the Paschal mystery of Christ, can indeed transform his condition as a sufferer into a time of grace for himself and others to the point of finding a vocation to love more in infirmity, a call to take part in God's infinite love for humanity" (no. 26).

To the numerous, praiseworthy endeavors already existing in this regard—such as the different patients' associations—there should be added others, like the introduction of the sick into Church organisms (pastoral councils and others), for example.

In regard to women's involvement in the world of health, the words of John Paul II in *Mulieris Dignitatem* hold great value. "Women's moral strength," the Pope writes, "their spiritual strength, derives from the awareness that God entrusts man, the human being, to them in a special manner. Of course, God entrusts man to each and every person. However, this charge refers to women, above all, precisely by reason of their femininity...." And he later adds, "In our time the successes of science and technology enable us to attain a previously unknown material well-being which, in favoring some, leads others to marginalization. This material progress may also involve a gradual disappearance of man's sensitivity to what is essentially human. In this sense, our time, above all, is awaiting the manifestation of the *genius* of women to ensure sensitivity to man in every circumstance: simply because he is man!" (no. 30)

If what the Pope affirms is valid for every context, it is especially for the world of health, where man, in experiencing the fragility of his being, can easily fall victim to indifference and violence. Women's taking part more actively and responsibility in the Church's mission in the health world would lead to significant changes in postures regarding persons and problems therein. Would it not be salutary to see the Church's presence and action and her language, theology, and perception of reality and God more deeply enriched by the characteristics which are typical of the female personality: receptivity, availability, acceptance, a capacity for listening, skill in grasping situations, an aptitude for taking on the burden of others' problems, and an inclination towards offering one's help? As in civil society, so, too, in the Church, women are perhaps awaiting fewer flowery compliments and more consideration, fewer signs of deference and greater responsibility in Church organisms of every kind. As *Christifideles Laici* rightly states, "the basic reason which demands and accounts for the simultaneous presence of men and women is not only the greater significance of the Church's pastoral action, and much less the simple sociological fact that humanity is made up of men and women. The Creator's original design is much more, for 'from the beginning' He has wanted the human being to be the 'unity of two'" (no. 52).

The second question concerns the conditions needed so that the shift will occur from a health ministry placing responsibility on others or implying passive participation to one characterized by active involvement.

There is no doubt that one of the first conditions consists of fruitfully relating the different charisms and ministries so that a real sharing of responsibility will be achieved. We can in fact speak of shared responsibility only when there is awareness of *having to respond* and when the conditions exist to make one's responses operative. In our Churches, is this operative awareness or possibility present? The journey has begun, but there is still a long way to go. It is hard, for example, to see priests carrying out their ministry in such a way as to serve the diaconal or ministerial growth of all, a growth obtained through an involvement which does not degenerate into the role of *mere laborers, but which rises to the level of adequate sharing in responsibility*. To "construct the Church" in ways which truly honor the shared responsibility of all the baptized demands a profound change in mentality, the surmounting of multiple obstacles, such as individualism and the thirst for power, reticence towards lay people, especially women, and the still excessive dependency of the laity.

Another condition is the proper functioning of structures for communion and stimulus. If these structures—

that is, the different consulting bodies and associations, the chaplaincies, and the pastoral councils at hospitals—do not function adequately, we shall always be left with pastoral care based on spontaneity going no further than gestures of good will and generosity without becoming an authentic pastoral project involving all the forces present in the Church community.

This *proper functioning* must first be promoted in each structure and then be coordinated with others.

Unquestionably, it often hard to understand the resistance—on the part of bishops and priests—to the creation of a *chaplaincy*, understood to be a pastoral team made up of priests "to which deacons, religious, and lay people may also be added," as the Italian Bishops' *Note* affirms (no. 79). How can we conceive otherwise of pastoral care in the future, it is asked, if we consider the decrease in numbers of priests and their aging? Is there nothing to be learned from the example of many other countries, where the chaplaincy has already been active for many years? Why don't the Catholic health facilities grouped together under the aegis of ARIS provide an example in this area, since they do not face the legal difficulties appearing at public hospitals?[20]

As for the pastoral council at hospitals, it should be noted that, though it does not yet exist at many health facilities, it is seen to be not only possible, but also valid.

In relation to associations of health professionals, we cannot fail to admire the effort they are making to combat the crisis many groups are facing, as well as their organizational capacity, evidenced in national and regional conferences and in some training programs, but we remain more perplexed over the internal life of these bodies and their impact on the professions they represent.

Volunteers rightly prompt applause and admiration. But how can we overlook the frequent instances of inadequate preparation, selection, and coordination affecting different associations at work in the same community?

Among the groups meriting distinction, AIPAS should be singled out (the Italian Association for the Healthcare Ministry). Bringing together chaplains and other health workers, both priests and laity, young and well thought out, it is experiencing encouraging growth.

If it is essential to stimulate each facility, it is just as important to coordinate all the organisms, groups, and associations working in health care.

In the context of these different groups, how can we fail to observe the overlapping, competitiveness, and lack of adherence to and cooperation in a shared project? I find it hard to understand the existence of two associations (AMCI and ACOS) which are both open to physicians.

The work of coordination and stimulus must be carried out at different levels and by different bodies. At health facilities responsibility falls to the chaplaincy and, when it exists, the pastoral council; in parishes, to the pastor and his council; in dioceses, to the diocesan council or commission; in regions, to the regional council; and, in the case of the whole peninsula, to the National Council.

The activity of coordination and stimulus should aim to develop projects and create the conditions in which these projects can be carried out. There are thus a number of functions to perform. Along with the organizational aspect, we must not neglect discernment and verification—what priorities are to be selected, what routes should be followed, and what changes must be made?

By way of example, I shall start with a very recent study in the Diocese of Milan. One of the results deserves attention. Most of those interviewed expressed a "positive evaluation of religion and the Church in their civil and social role: aiding the poor, solidarity, tolerance..., whereas there is much less attention to the transcendent dimension of the Church and her Gospel inspiration."[21] One of the analysts comments as follows: "There is a bit of an ecclesiastical 'services sector' among us: so many departments, organization, a great deal of involvement.... But the most urgent thing is to evangelize. We go on talking, but we are still not convinced we have to reconstruct the Christian fabric all over again" of the Church communities.

What do such data and this reflection say to the Christians working in health care, to the health facilities organized so well by ARIS, to volunteer groups, and to those who are involved in humanizing service to the sick?

Who should bring these questions to the attention of those active in health and pastoral care—at times excessively unaware of them—if not the organisms responsible for stimulus and coordination?

IV. At the conclusion of this overview, I take the liberty of inviting Your Eminence and Your Excellencies to give all due consideration to the healthcare ministry, which, as John Paul II states, is an "integral part of the mission of the Church" (*DH* 1). "Christianity has a message of life to announce not only to those who suffer, but also to those who choose to assist and accompany the sick" (no. 18).

Among the means to update this attention, I would like to recall the following.

* To write a pastoral letter on suffering, health, and the commitment falling to the local Church (diocese or parish) as regards carrying out St. Paul's words: "If one member of the community suffers, the whole community suffers."

* To involve those working in the health apostolate in the cultural project of the Italian Church to foster more effective action in the places where culture is shaped.

* To unite meetings with personnel, especially doctors, to visits to the sick.

* To promote and accompany the charisms of merciful charity towards the suffering.

* To foster the specialized training of chaplains.

* To facilitate and promote the inclusion of women religious and lay people in chaplaincies.

I shall conclude by wishing you good physical and spiritual health, that it may be a source of integral health for those you reach through your episcopal ministry.

Rev. ANGELO BRUSCO
Superior General of the Camillians

Notes

[1] The documents of the Italian Bishops' Conference cited in this section may be found in the *Enchiridion CEI* (Bologna: EDB).

[2] *La pastorale della salute nella Chiesa italiana* (Bologna: EDB, 1989). An exhaustive commentary on the *Note* is found in A. BRUSCO (ed.), *Curate i malati. La pastorale della salute nella Chiesa italiana* (Turin: Camilliane, 1990).

[3] The Italian Bishops' Conference, *A servizio della vita umana* (Rome: A.V.E., 1990), p. XI.

[4] The document by the Italian Bishops' Conference on *Evangelization and the Culture of Human Life* was written at the end of the National Meeting entitled "In Service to Human Life," held in Rome, April 13-16, 1989.

[5] Cf. L. SALVINO, *La pastorale sanitaria nel magistero della Chiesa* , 1 (Rome: Biblioteca Ospedaliera, 1994).

[6] A. BRUSCO, "Evangelizzazione e testimonianza della carità," in *Anime e corpi*, 162 (1992), 356 and "La pastorale della salute nella Chiesa italiana," in *Medicina e morale*, 3(1990), 475-476.

[7] Cf. A. BRUSCO, *Curate i malati*, *op. cit.*, pp. 203-212.

[8] G. BIFFI, *I malati nella comunità ecclesiale* (Bologna: EDB, 1987). We should recall the texts prepared by different diocesan councils for the health apostolate (e.g., Padua and Venice).

[9] C.A. MORO, "Nuove possibili frontiere di una carità operosa," in *Orientamenti pastorali*, 2 (1991), 43.

[10] C.A. MORO, *op. cit.*, p.43.

[11] A. BRUSCO, "La nuova evangelizzazione della croce nella Chiesa particolare," in *Croce e nuova evangelizzazione* (Rome: Centro Volontari della Sofferenza, 1994), pp. 217-233.

[12] *L'Osservatore Romano*, May 20, 1995, 5.

[13] *Dolentium Hominum*, no. 3.

[14] Cf. L. SANDRIN, "Il mondo della sanità e il ruolo delle persone consacrate," in *Religiosi in Italia*, 298 (1997), 12.

[15] *Ibid*.

[16] Cf. M. ALBERTON, *Solitudine e presenza* (Bologna: EDB, 1974).

[17] F. ALVAREZ, "La nuova evangelizzazione nel mondo della salute. Prospettive teologico-pastorali," in *La vita consacrata nel mondo della salute* (Rome: Quaderni del Camillianum, No. 4, 1993), p. 54.

[18] Cf. I. MONTICELLI, "L'estensione della pastorale dall'ospedale al territorio," in A. Brusco, *CurateÉ*, *op. cit.*, pp. 87-97.

[19] Cf. P. NONIS, "Chiesa e carità in Italia, oggi e domani," in *Orientamenti pastorali*, 2 (1991), 35-42.

[20] For all topics relating to the chaplain and the chaplaincy, see S. Marinelli, *Il cappellano ospedaliero, identità e funzioni* (Turin: Camilliane, 1993) and A. BRUSCO and L. SANDRIN, *Il cappellano ospedaliero, disagi e nuove opportunità* (Turin: Camilliane, 1993).

[21] R. BERETTA, "Basta 'terziario religioso.' Torniamo all'essenziale," in *Avvenire*, April 9, 1995, 21.

Activity of the Pontifical Council

Activity of the Pontifical Council for Pastoral Assistance to Health Care Workers in 1997

Sections

1. The Appointment of the new Council President

On August 20, 1996 the Holy Father, John Paul II, appointed the Most Rev. Javier Lozano Barragán, Bishop of Zacatecas, Mexico, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, conferring upon him the title of Archbishop. Archbishop Lozano took office on January 9, 1997. His Eminence Fiorenzo Cardinal Angelini, the first Council President, was also present on this occasion.

2. Celebration of the Fifth World Day of the Sick

The solemn celebration of the Fifth World Day of the Sick took place this year at the Sanctuary of Our Lady of Fatima. The Pontifical Delegation, headed by Cardinal Fiorenzo Angelini, included Rev. José L. Redrado, O.H., Council Secretary; Rev. Felice Ruffini, M.I., Council Undersecretary; Monsignor Giacomo Giampietruzzi, Secretary of the Apostolic Nunciature in Portugal; Professor Walter Osswald, President of

the International Federation of Catholic Medical Associations; and Professor Daniel Serrao, Member of the Pontifical Academy for Life. Cardinal Angelini was also accompanied by the following guests of honor: Cardinal Andrej Deskur, Emeritus President of the Pontifical Council for Social Communications; Archbishop Javier Lozano Barragán, new President of the Pontifical Council for Pastoral Assistance to Health Care Workers; and a group of about 120 persons, including Council officials and consultors, representatives of Catholic associations and federations in the health field, hospital chaplains, and men and women religious. The group was made up of pilgrims from Italy, Spain, Mexico, France, Belgium, Poland, India, and Romania. Readers may consult the corresponding issue of this journal for ample coverage (*Dolentium Hominum*, no. 35/1997).

3. Interdepartmental Meetings

* At the Secretariat of State, the Council President, Archbishop Lozano, took part on February 28 and March 1 in an interdepartmental meeting devoted to major UN Conferences in recent years—on children (New York, 1990), on the environment (Rio de Janeiro, 1992), on human rights (Vienna, 1993), on population (Cairo, 1994), on social development (Copenhagen, 1995), on women (Beijing, 1995), and on human settlements (Habitat II, 1996). The purpose of the meeting was to examine the progress made, results achieved, commitments taken on, and foreseeable consequences for the Holy See in connection with these conferences.

* At the Pontifical Council for Culture, March 13-15, Archbishop Lozano took part—in his capacity as a Member of that Council—in the Plenary Assembly, bearing the title "For a Pastoral Approach to Culture."

* At the Pontifical Council for Justice and Peace, Council Secretary Rev. José L. Redrado, O.H. took part on April 4 in an interdepartmental meeting to prepare for *World Peace Day* (1998).

* At the Pontifical Council Cor Unum, April 16-19, Rev. José L. Redrado took part as a Consultor in the Twenty-Second Plenary Assembly of the Council.

* At the Pontifical Council for Culture, on June 16 Rev. Krzysztof Nykiel, official of the Council, took part in an interdepartmental meeting entitled "Sects: Context and Cultural Challenges."

4. Attendance at Conferences and Meetings

JANUARY

* 13-22: In Geneva Council official Monsignor Jean-Marie Mpendawatu took part in the ninety-ninth session of the Executive Council of the World Health Organization, particularly devoted to the reforms going on at that organization.

* 17: Council Undersecretary Rev. Felice Ruffini, M.I., took part as a Member in the meeting of the Technical Committee for the Great Jubilee of the Year 2000 at Committee headquarters. He thereafter attended the other meetings held periodically throughout the year.

FEBRUARY

* 14: The Council President, Archbishop Lozano, inaugurated the Sessions of the Third General Assembly of the Pontifical Academy for Life, with an address concerning "The Identity and Statute of the Human Embryo."

MARCH

* 12-14: In Geneva Monsignor Jean-Marie Mpendawatu, official of the Council, formed part of the Holy See Delegation at the International Conference on "Ethics, Equity, and Renewal of the WHO's *Health for All* Strategy," organized by the Council for International Organizations of Medical Sciences (CIOMS) and WHO. APRIL

* 16: The President, Archbishop Lozano, inaugurated the new headquarters of the Clinical Institute for Infectious Diseases at the Catholic University of the Sacred Heart in Rome, in the presence of public and academic officials: Italian Health Minister Rosy Bindi; Professor Adriano Bausola, Rector of the University of the Sacred Heart; Dr. Antonio Cicchetti, Administrative Director of the Polyclinic; and Professor Luigi Ortona, Director of the Institute.

* 18: In Gand, Belgium, Archbishop Lozano took part in the International Conference on the "Quality of Life," organized by the Congregation of the Brothers of Charity. He spoke on "The Apostolic Charism of Healing."

* 28: With a greeting for participants Archbishop Lozano inaugurated the Seventh Ordinary Meeting of the Executive Council of the Pontifical Academy for Life.

MAY

* 5-8: In Geneva, Archbishop Lozano, as the head of the Holy See Delegation, took part in the Fiftieth World Health Assembly and spoke on "The Demands of Health and Morality: The Health Model in WHO." Monsignor Jean-Marie Mpendawatu, official of the Council, also formed part of the Delegation.

* 13: In Rome, the Council President greeted those taking part in a Conference on "Medicine and Spirituality: An Ancient and Modern Bond for Care of the Person," organized by the International Institute for the Pastoral Theology of Health Care—Camillianum, in collaboration with the Institute for Bioethics of the Catholic University of the Sacred Heart.

* 19-27: In Monterrey, Mexico, Archbishop Lozano took part in a Conference on "The Christian Meaning of Sexuality," organized by the Pontifical Council for the Family; he spoke on "The Demands of Health and Morality: The WHO Health Paradigm."

JUNE

* 1: At the Pontifical Urban University in Rome Archbishop Lozano addressed a greeting to those taking part in the Tenth European Congress on Physical Medicine and Rehabilitation:

* 12-14: In the Old Synod Hall at the Vatican, Archbishop Lozano took part in the Symposium organized by the Pontifical Council for the Family in collaboration with the Center for Special Family Education in Madrid and spoke on "Families Dealing with Brain Alterations in Children."

SEPTEMBER

* 15-19: In Istanbul, Council official Monsignor Jean-Marie Mpendawatu represented the Holy See at the Forty-Seventh Session of the WHO European Regional Committee.

* 29-30: In Madrid, Archbishop Javier Lozano and Rev. José L. Redrado took part in the Twenty-Second National Health Ministry Day. The Council President spoke on "Volunteers in the Church in the Doctrine of John Paul II."

OCTOBER

* 12-25: In Salice Terme, Italy, the Council Secretary, Father Redrado, attended the extraordinary General Chapter of the St. John of God Brothers.

* 14: In Collevalenza, Italy, the Council President greeted those attending the National Meeting of the Italian Association for the Health Apostolate (AIPAS) on "Cooperation Between Health Facilities and Parishes."

* 17: Council official Monsignor Mpendawatu took part in the second meeting of the Secretariat of State on matters being dealt with by international organizations and agencies.

NOVEMBER

* 3-7: In Paris, Monsignor Mpendawatu formed part of the Holy See Delegation at the Twenty-Ninth General Conference of UNESCO.

* 14: In Rome, Archbishop Lozano met with the Ambassadors to the Holy See from Latin America, the Philippines, and Portugal and spoke briefly on the role of an ambassador to the Holy See.

* 16-December 12: The Council President took part in the Special Assembly for America of the Synod of Bishops as a permanent member thereof.

* 21: At the Apostolic Palace in Loreto, the Council Secretary, Rev. José L. Redrado, took part in the press conference to present the program for the Sixth World Day of the Sick, to be celebrated on February 11, 1998.

* 26-28: In Santiago, Chile Archbishop Lozano represented the Holy See at the Seminar on "Policies and Applications of Technology to Control Drugs and Psychotropic Substances" organized by the Chilean government. He spoke on "The Vatican's Ethical and Moral Position Regarding Drugs."

DECEMBER

* 2-5: In Fatima, Rev. José L. Redrado took part in the Eleventh National Meeting on the Health Ministry.

5. Pastoral Visits and Trips

MARCH

* 25: In preparation for Easter, Archbishop Lozano visited the Celio Military Hospital in Rome, where he celebrated the Eucharist and conferred the sacrament of Confirmation upon a number of soldiers.

JULY

* 6: On the feast of St. Camillus de Lellis, Archbishop Lozano, accompanied by the Council Undersecretary, Rev. Felice Ruffini, M.I., presided at a concelebrated Mass at the Holy Family Clinic in Rome.

* 21: On the feast of St. Daniel, Archbishop Lozano, accompanied by Father Redrado, O.H., presided at a concelebrated Mass at the St. John of God Brothers' St. Peter's Hospital and inaugurated the new facilities for the hospitality center.

SEPTEMBER

* 20: Having been invited by the Most Rev. Jean Sahuquet, Bishop of Tarbes and Lourdes, Archbishop Lozano visited Lourdes for the solemn blessing of the new *Accueil Notre Dame* and presided at the Solemn Mass at the St. Pius X Basilica.

NOVEMBER

* 3: Accompanied by the Council Secretary, Father Redrado, Archbishop Lozano, at the St. John of God Brothers' *Ospedale San Giovanni Calibita* (Isola Tiberina, Rome), presided at a Mass marking the centennial of the birth of St. Riccardo Pampuri.

6. Church Meeting on Drugs

The Pontifical Council for Pastoral Assistance to Health Care Workers organized a Church Meeting on Drugs, "United for Life," held at the Vatican's Old Synod Hall, October 9-11, 1997.

The purpose of the meeting was to examine the involvement by all those active within the Church—dioceses, religious institutes, associations, rehabilitation groups, and volunteers—throughout the world to curb the phenomenon through prevention and rehabilitation of addicts, in full respect for the values of life and the dignity of every human being, and to facilitate the rapid preparation of a pastoral manual for the care of drug addicts. Ninety people attended, representing forty-five countries and characterized by their extensive experience in prevention and rehabilitation. They commented on the major methods now being applied around the world to deal with this problem.

The Meeting opened with an address by Cardinal Angelo Sodano, Secretary of State, who set forth the key orientations of papal teaching in this regard, which may be summarized under seven headings—the scourge of drugs, devastat-

ing effects, public responsibility, ethnic and cultural roots of the phenomenon, an adequate strategy, a challenge for the Church, and the horizon of hope. In the course of the meeting different anthropological and theological reflections were presented on the harmony of the person and drugs, drugs and the value of the body, education aimed at advancing life, and the person as a value. Afterwards there were exchanges dealing with varied experiences with prevention and rehabilitation and the role of the family and society. Other subjects were also dealt with, such as the biological roots of addiction, drugs and criminality, the fight against drugs and international norms. Significant messages were received as well from the UN office in Vienna, from the WHO office for drugs, and from the European Addiction Observation Center in Lisbon. At the conclusions of the sessions, the Holy Father delivered an address which stressed that the fight against this scourge of addiction is everyone's duty, in keeping with personal responsibilities.

7. Twelfth International Conference

A particularly important occasion for the work of the Pontifical Council for Pastoral Assistance to Health Care Workers was afforded by the Twelfth International Conference, held at the Vatican's New Synod Hall, November 6-8, 1997, and entitled "Church and Health in the World: Expectations and Hopes on the Threshold of the Year 2000—*Gratia Eius Salvati Estis* (Eph 2:8)." It was situated in the context of celebrations for the Great Jubilee and the themes which the Pope had established for 1997 in his *Tertio Millennio Adveniente*: Jesus Christ, the Incarnate Word of God, the source of health for all.

The Conference brought together about 450 participants from eighty countries—there were 22 ambassadors, 200 doctors, and representatives of Catholic associations and federations in the health field. Among the fifty distinguished speakers there were three cardinals, the Portuguese Minister of Health, five bishops, two ambassadors, and many outstanding researchers, scientists, and students of bioethics, the history of medicine, biomedicine, philosophy, ethics, sociology, law, and moral and pastoral theology. Cardinal Pio Laghi, Prefect of the Congregation for Catholic Education, opened the Conference, speaking on

"Jesus, Incarnate Word, Health and Salvation for Man." Portuguese Health Minister Maria de Belem Roseira spoke on sociopolitical and economic aspects of health, and WHO Director General Hiroshi Nakajima wished to stress the importance of international cooperation for solidarity at a round-table series of talks.

The Holy Father, at the conclusion of the Conference sessions, urgently appealed for the health field to free itself from the dynamics of profit and allow itself to be permeated by the logic of solidarity and charity. In addition, he wished to recall the great witness to love for the suffering provided by Mother Teresa of Calcutta.

8. Publications

Dolentium Hominum. Church and Health in the World, Journal of the Pontifical Council for Pastoral Assistance to Health Care Workers, published three times a year, has appeared regularly and is increasingly well received among health professionals around the world. It is available in four different language editions (Italian, Spanish, French, and English). One issue each year contains the complete *Proceedings* of the annual International Conference organized by the Pontifical Council.

The Charter for Health Care Workers, published in 1994 under the auspices of the Council, is currently available in Italian, French, Spanish, German, Dutch, Polish, Portuguese, Russian, Czech, Rumanian, and Arabic. The Council has authorized versions in Hungarian and Lithuanian which are in the process of being published, and translations are also being done in Madagascan, Albanian, and Thai.

9. Conclusion

To close this summary report on the Council's activities, it should be added that throughout 1997 there has been intense, ongoing activity at our headquarters. The Pontifical Council for Pastoral Assistance to Health Care Workers, under the guidance of the new President, Archbishop Javier Lozano, has continued the work of ordinary correspondence with the bishops on specific questions connected with the problems of the health apostolate, bioethics, publishing, and various requests involving both personal contact with papal representatives (particularly those recently appointed), archbishops and bishops (residing in Rome or coming here for their *ad limina* visits or for other reasons), and priests and men and women religious active in the vast field of health.