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

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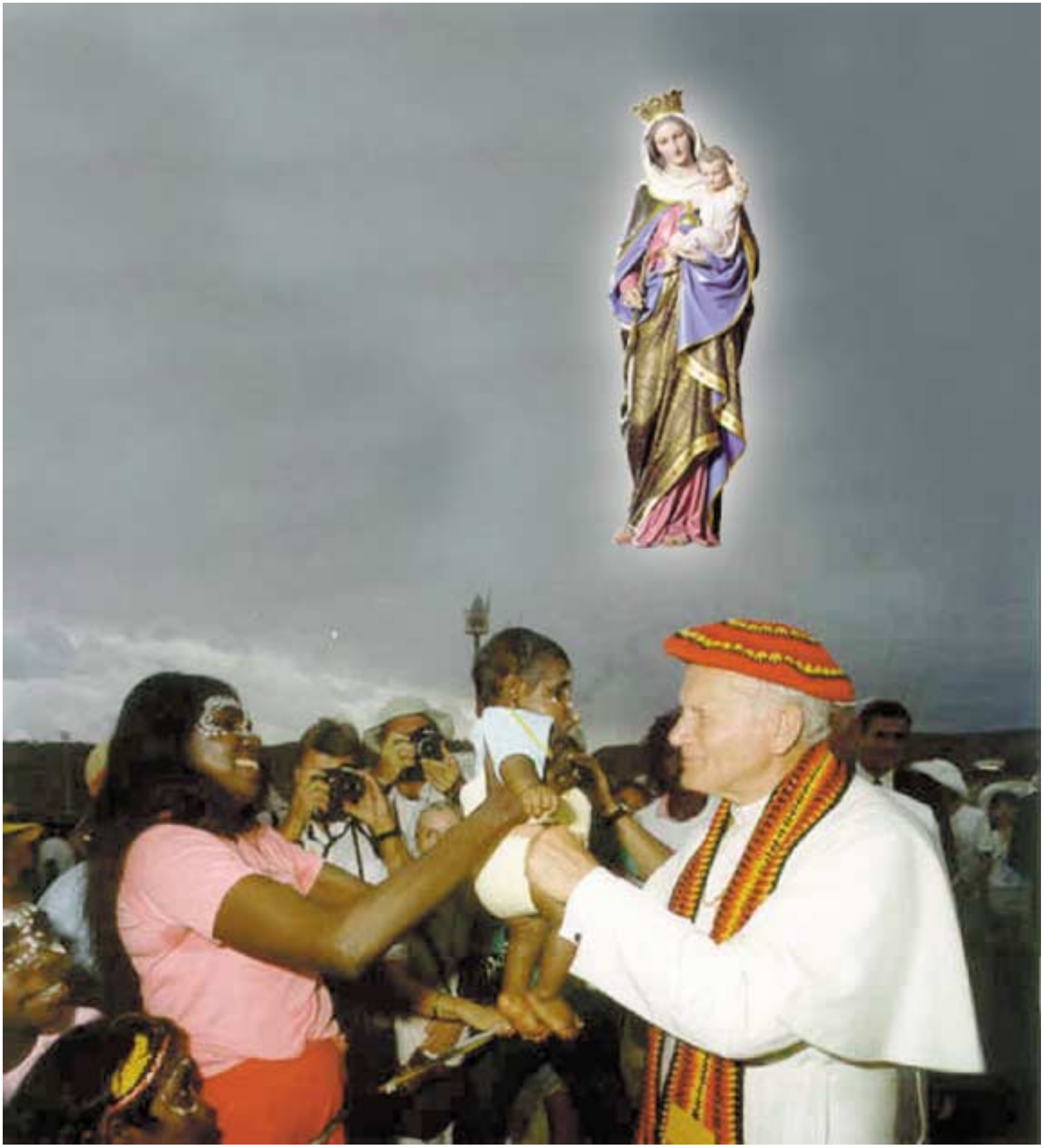


"I entrust you to Mary,
Mother of the Church..."

Message of the Holy Father for the IX World Day of the Sick Sydney, February 11, 2001

1. Enriched by the grace of the Great Jubilee and by contemplation of the mystery of the incarnate Word, in which human pain finds "its supreme and surest point of reference" (*Salvifici Doloris,* n. 31), the Christian community is preparing to celebrate the Ninth World Day of the Sick on 11 February 2001. The place designated for the celebration of this significant event is the cathedral of Sydney, Australia. The choice of the Australian continent with its cultural and ethnic wealth highlights the close bond of ecclesial communion: this bond transcends distances and fosters the encounter of different cultural identities made fruitful by the one liberating message of salvation.

The cathedral of Sydney is dedicated to the Blessed Virgin Mary, Mother of the Church. This fact emphasizes the Marian dimension of the World Day of the Sick, which has now been observed for nine years on the memorial of Our Lady of Lourdes. As a loving Mother, Mary will once again enable not only the sick on the Australian continent to feel her protection, but also all who dedicate their professional skills and often their whole lives to serving them.

As in the past, the Day will be an occasion of prayer and support for the countless institutions devoted to the care of the suffering. It will encourage the many priests, religious and lay believers who seek to respond in the Church's name to the expectations of sick people, while paying special attention to the weakest and those struggling the most, in order to assure the victory of the culture of life over the culture of death everywhere (cf. *Evangelium Vitae,* n. 100). Since I too have shared the experience of illness several times in recent years, I have come to understand more and more clearly its value for my Petrine ministry and for the Church's life itself. In expressing my affectionate solidarity to those who are suffering, I invite them to contemplate with faith the mystery of Christ crucified and risen, in order to discover God's loving plan in their own experience of pain. Only by looking at Jesus, "a man of sorrows, and acquainted with grief" (Is 53:3), is it possible to find serenity and trust.

2. On this World Day of the Sick, whose theme is *The New Evangelization and the Dignity of the Suffering Person,* the Church intends to stress the need to evangelize in a new way this area of human experience, in order to encourage its orientation to the overall well-being of the person and the progress of all people in every part of the world.

The effective treatment of various pathologies, commitment to further research and the investment of adequate resources are praiseworthy objectives which have been successfully pursued in vast areas of the globe. However, while applauding the efforts made, one cannot overlook the fact that not everyone enjoys the same opportunities. I therefore make a pressing appeal that everything be done to encourage the necessary development of health services in the still numerous countries which are unable to offer their inhabitants proper living conditions and appropriate health care. I also hope that the vast potential of modern medicine will be put at the effective service of human beings and applied with full respect for their dignity.

In her 2,000-year history, the Church has always tried to support therapeutic progress for the sake of ever improved assistance to the sick. She has intervened in various situations with every means at her disposal to see that the rights of the person are respected and his authentic well-being always pursued (cf. *Populorurn Progressio,* n. 34). Today too, faithful to the principles of the Gospel, the Magisterium never ceases to offer moral criteria to guide medical personnel in studying those aspects of research which have not yet been sufficiently clarified, without violating the requirements of an authentic humanism.

3. Every day I go on a spiritual pilgrimage to hospitals and treatment centres, where people of every age and social background live. I would particularly like to pause beside the patients, their recitatives and the health-care personnel. These places are like shrines where people participate in Christ's paschal mystery. Even the most heedless person is prompted there to wonder about his own life and its meaning, about the reason for evil, suffering and death (cf. *Gaudium et Spes,* n. 10). This is why it is important that the skilled and significant presence of believers should never be wanting in these structures.

Therefore how could I not make a pressing appeal to medical and nursing professionals to learn from Christ, the physician of souls and bodies, to be authentic "Good Samaritans" towards their brothers and sisters? In particular, how could I not hope

that everyone dedicated to research will work tirelessly to identify suitable ways to promote the integral health of the human being and fight the consequences of diseases? How could I not, in addition, encourage those who are directly involved in the care of the sick to be always attentive to the needs of the suffering, combining skill and humanity in their professional life?

Hospitals, centres for the sick or the elderly and every institution which cares for the suffering are privileged areas for the new evangelization, which must be committed to making the Gospel message of hope heard precisely in these places. Only Jesus the divine Samaritan is the fully satisfying answer to the deepest expectations of every human being in search of peace and salvation. Christ is the Saviour of every person and of the whole person. For this reason the Church never tires of proclaiming him, so that the world of illness and the search for health may be enlivened by his light.

It is important, then, that at the beginning of the third Christian millennium a new impetus be given to the evangelization of the world of health as a place particularly suited to becoming a valuable laboratory for the civilization of love.

4. In recent years, there has been a growing interest in scientific research in the medical field and in the modernization of health-care structures. We can only look favourably at this trend, but at the same time it must be stressed that there is a constant need for it to be guided by the concern to offer the sick an effective service, supporting them efficaciously in the fight against disease. In this perspective, there is increasing discussion of “holistic” care, that is, care that pays attention to the biological, psychological, social and spiritual needs of the sick and of those around them. It is particularly necessary, with regard to medicines, treatments and surgical operations, for clinical experimentation to be conducted with absolute respect for the individual and with a clear awareness of the risks and, consequently, of the limits involved. In this area Christian professionals are called to bear witness to their ethical convictions and to be constantly enlightened by faith.

The Church appreciates the efforts of those who, by engaging in research or treatment with dedication and professionalism, help to improve the quality of the service offered to the sick.

5. The equitable distribution of goods, desired by the Creator, is also an urgent im-

perative in the area of health: the persistent injustice that deprives a large part of the population of the treatment indispensable to health, especially in poor countries, must cease once and for all. This is a grave scandal which can only prompt national leaders to make every effort to ensure that those who lack material means are provided with access to at least basic health care. Promoting "health for all" is a primary duty for every member of the international community; for Christians it is a commitment closely connected with their witness of faith. They know that they must proclaim the Gospel of life in a practical way by promoting respect for it and rejecting every kind of attack on it, from abortion to euthanasia. Reflection on the use of available resources also belongs in this context: their limitedness calls for the establishment of clear moral criteria to guide the decisions of patients or their guardians regarding extraordinary procedures which are expensive or risky. In any case, recourse to forms of aggressive medical treatment should be avoided (cf. *Evangelium Vitae*, n. 65).

Here I would like to praise the individuals and structures, and especially religious institutions, which perform a generous service in this sector by courageously responding to the urgent needs of persons and peoples in regions or countries of great poverty. The Church expresses to them a renewed appreciation of the contribution they continually make in this vast and sensitive apostolate. I would like, in particular, to urge the members of religious families involved in the health-care ministry to respond boldly to the challenges of the third millennium, following in the footsteps of their founders. In view of the new tragedies and diseases which have replaced the plagues of the past, there is a pressing need for the work of "Good Samaritans" who can offer the sick the treatment they need, but at the same time provide them with spiritual support to endure their difficult situation with faith.

6. I extend a particularly affectionate thought to the many men and women religious who, with an ever increasing number of lay people, are writing wonderful pages of Gospel charity in hospitals and health-care centres. They often work in frightening war zones and daily risk their lives to save those of their brethren. Unfortunately, many have died for their service to the Gospel of Life.

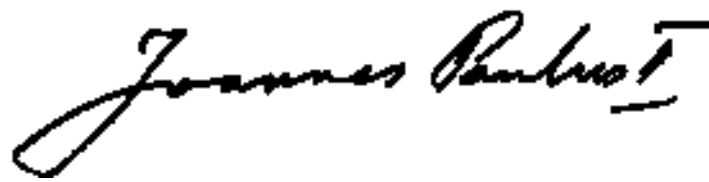
I would also like to mention the many non-governmental organizations which have recently arisen to help those disadvantaged in the area of health. They can rely on the contribution of "on-site" volunteers, as well as on the generosity of a large

number of people who financially support their activity. I encourage them all to continue this praiseworthy work, which in many nations is sensitizing consciences in a significant way.

Lastly I address you, dear sick people and generous health-care professionals. This World Day of the Sick is taking place shortly after the conclusion of the Jubilee Year. It is therefore a renewed invitation to contemplate the face of Christ, who became Man 2,000 years ago to redeem man. Dear brothers and sisters, proclaim and bear witness to the Gospel of life and hope with generous dedication. Proclaim that Christ is the comfort of all who are in distress or difficulty; he is the strength of those experiencing moments of fatigue and vulnerability; he is the support of those who work zealously to assure better living and health conditions for everyone.

I entrust you to Mary, Mother of the Church, to whom, as I recalled at the beginning, the cathedral of Sydney, the spiritual centre of the Ninth World Day of the Sick, is dedicated. May Our Lady of Consolation make her motherly protection felt by all her suffering children; may she help you bear witness before the world to the tenderness of God and make you living icons of her Son!

With these wishes I impart a special Apostolic Blessing to you and to all your loved ones.



From Castel Gandolfo, 22 August 2000.

Jubilee Day of the Sick and Health Care Workers

CURATE INFIRMOS

VIII World Day of the Sick,
Rome, 9-11 February 2000

That Suffered and Joyful Prayer of so many People Confined to Wheelchairs *

11 February 2000 in St. Peter's Square – a cosmic embrace of the world of suffering on the day of the jubilee of the suffering and health care workers. A liturgical celebration with the Virgin Mary of Lourdes. In the Grotta di Massabiele with our Lady dressed in white, with wheelchairs, cots, and stretchers, and so many sick people, as well, on their beds of pain, who today more than ever before renew an encounter of communion. Souls and hearts, close by and far away, linked to that thread of love and hope which is faith in the Cross of Christ which redeemed the world.

St. Peter's Square was like a great and immense open-air aisle. 2,400 sick people in wheelchairs and 1,700 people standing at the feet of the statues of St. Peter and St. Paul. Family relatives, medical doctors, paramedics, nurses, people who accompany them, and voluntary workers. Wounded bodies, bodies full of pain. But on their faces there was so much joy and so much Christian hope.

From the altar the Pope greeted the assembly with the following words: "The Lord Jesus revealed the presence of the Kingdom of God amongst men with marvellous signs which accompanied his words. Mary, his Mother, still sings with us the wonders of the Father because he saw the humility of his handmaiden. The whole Church exults", continued the Pope, "at the gift of the spirit effused over each of her children through the sacraments. We, too, gathered together to render thanks to the Lord together with our sick brothers and sisters experience the beauty of the grace which radiates in our weakness. To celebrate this solemn action of graces in a worthy way, we ask for forgiveness for our sins".

The Statue of the White Lady of Lourdes

Next to the altar the white statue of the Madonna of Lourdes. And fifty concelebrants with white chasubles, amongst whom Cardinal Etchegary, President of the Committee of the Great Jubilee of the Year 2000, with its Secretary, Archbishop Sepe; the President of the Pontifical Council for Health Pastoral Care, Archbishop Lozano Barragán, and forty-seven archbishops and bishops made responsible for pastoral care in health by their episcopal conferences. Thirty-nine priests involved throughout the world in the health care ministry also took part in the celebration.

There were also the singers of the Sistine Chapel, directed by Maestro Giuseppe Liberto, and they sang the invocations, after a brief pause of silence: "Lord, shining light in the darkness who illuminates every man, have mercy on us". "Kyrie, elieson", replied the assembly with the Gregorian chant. "Christ, first-born Son of the Father, born of a woman, born under the law to redeem man from every slavery". "Christe eleison", answered the assembly once again. "Lord, light of the divine glory, who purifies man of sin, have mercy on us". "Kyrie, eleison", concluded the assembly.

John Paul II then intoned the "Gloria" and immediately afterwards the collect oration: "Grant to your faithful, our Lord God, to always enjoy the health of the body and of the spirit and by the glorious intercession of the Most Holy Mary, always virgin, save us from the evils which now sadden us, and lead us to joy without end".

In Spanish Renzo Paccini read out a passage from the Prophet Isaiah: "I will make prosperity flow towards you like a river". After the responsorial psalm sung by Michel Galcotti, An Verlinde in English read a passage from the Letter of St. James the Apostle: "who amongst you is in pain, pray; who is in joy sing psalms. Who is sick, call to him the presbyters of the Church and let them pray upon him, after anointing him with oil in the name of the Lord. And the prayer said in faith will save the sick man". Before everybody's eyes the precept was carried out and the wonder was performed.

The deacon Dino Mulassano sung the Marian gospel of Luke: the visit of Mary to St. Elizabeth and the 'Magnificat' of the Virgin of Nazareth: "Great things the Almighty has done in me and holy is his name".

The liturgy of anointing then followed with the litany prayer and the laying on of hands. "Brothers", said the Pope, "we turn to the Lord the prayer of faith for our infirm brothers and for all those who treat them and take care of them". The ministering deacon Don Stefano Maffei invited the assembly to invoke the Almighty: "Hear us O Lord!". The deacon then raised to heaven the intentions: "May the

Lord bless the infirm; give them strength and health; lighten their suffering!" The intentions were then widened: "May all sick people feel the comfort of his grace; may his blessing accompany those who take care of the sick; may these sick people through the holy anointing with the laying on of hands obtain life and salvation".

The Liturgy of the Laying on of Hands

The Holy Father laid his hands on the heads of ten sick people while another eight concelebrants did the same to one hundred and ninety sick people placed at the sides of the parvis. There then followed the prayer of the "bestowing of graces through oil" and of the "holy anointing" on the foreheads and the hands of the sick people. "By this holy anointing and by his most holy mercy may the Lord help you with the grace of the Holy Spirit. And, freeing you from sins, save you and in his goodness raise you". During the 'Liturgy of the Anointing' the Holy Father was helped, among others, by Archbishop Mons. Javier Lozano Barragán, President of the Pontifical Council for Health Pastoral Care; Mons. Crescenzio Sepe, Archbishop, Secretary General of the Committee of the Great Jubilee of the Year 2000; Mons. Allesandro Plotti, Archbishop of Pisa, President of Unitalsi; Mons, José Luis Redrado Marchite, O.H., Secretary of the Pontifical Council for Health Pastoral Care; Rev. Pascual Piles Ferrando, Superior General of the Hospiteller Order of St. John of God (Fate Bene Fratelli); Rev. Angelo Brusco, Superior General of the Regular Priests Ministers to the Sick (Camillians); and Rev. Felice Ruffini, M.I., Under-Secretary of the Pontifical Council for Health Pastoral Care.

The Prayer to the Father and the Intercession of Mary

In the prayer to the faithful, in Portuguese, Sister Laurinda Faria, Councillor General of the Hospital Sisters of the Sacred Heart, spoke the following words: "O Father, whose only Son took upon himself the poverty and the weakness of all men, ensure that your Church knows how to bend in front of every man bent in his body and in his spirit and pour on him the oil of consolation and the wine of hope".

In Arabic Dr. Maya El-Hachen, head of the paediatric dermetological section of the 'Baby Jesus' hospital prayed as follows: "You who in every time raise men and women who by vocation and profession dedicate their lives to service to the sick, ensure that in their daily endeavour they are inspired by the example of Christ, Teacher and Lord".

In Polish Prof. Henryk Chmielewski, director of the neurological clinic at the military academy of medicine of Lodz, raised this invocation: "You who in the passion of your Son revealed to us the Christian value of suffering, ensure that to each sick person there does not lack the comfort of the Word and the sacraments of the faith".

Muhindo Mughanda in Swahili prayed with the following intention: "You who know the times and the moments of our lives, ensure that when we are visited by trials and pain we can experience the solidarity of those who, by your grace, enjoy good health".

In French Prof. Alain Lejeune, President of the International Federation of Catholic Pharmacists, then prayed as follows: "You who in this Jubilee Year invite us to rediscover our countenance as brothers and sisters around the sole table of the Body and Blood of your Son, hurry the day in which every tear will be dried and when we will finally be able to sit with you in refound peace".

The Holy Father concluded as followed: "God our Father, who, at the school of Christ your Son, revealed to us the hope which buds from the Cross, hear our supplications and provide us with the gift of receiving with joy the word and of putting it into practice with

commitment following the example of Mary, the Mother of your Son".

Sixteen people, who were infirm or health care workers, presented themselves in front of the Pope for the offering of gifts. Amongst others, there were presented three projects for health care structures for certain countries of the third world, a large candle, and a basket of flowers.

From Czestochowa to Fatima

Lourdes, Czestochowa, Yamoussoukro, Guadalupe, Fatima, and Harissa in the Lebanon – such were the Marian sanctuaries where over recent years the World Day of the Sick was celebrated. But St. Peter's Square, today, in the year of the Great Jubilee is the site for this celebration. The history of suffering continues. The heroism of the sons and the daughters of the Church who immolate themselves on the altar of suffering with heroism and with a dedication which is without limits also continues.

Around the altar were present the Cardinals Schwery, Bishop emeritus of Sion, Vincenzo Fagiolo, and Dino Monduzzi; Archbishop Rizzato, Almoner of His Holiness; Bishops James Michael Harvey, Prefect of the Pontifical Household, and Stanislaw Dziwisz, Substitute Prefect; Archbishop Remegio Ragonesi; Mons. Umberto Tramma, Bishop emeritus of Nola; the Maronite Bishop El-Hachem; and the members, the officials and the consultors of the Pontifical Council for Health Pastoral Care.

The reserved posts were for the Minister of Health of the Italian Government, Rosy Bindi, and other authorities. On the parvis amongst the sick brothers and sisters there was also present Kirk Kigour, a former volleyball champion, on a wheelchair for twenty years. There served at the altar the Regular Priests of the Ministers to the Sick (Camillians), of the Hospiteller Order of St. John of God (FateBene Fratelli), and of the Urban Pontifical Council. The choir of San Vito di San Vito dei Normanni (Brindisi) accompanied the liturgical singing.

One thousand five hundred faithful who had arrived on a Jubilee pilgrimage from Massa Carara were on the Loggia del Maggiordomato.

When the celebration had finished the Holy Father entered the jeep and descended into the square to greet, comfort and bless the sick people who were present.

On their faces full of light there shone joy and the sun of spring.

Rev. GIANFRANCO GRIECO

* From *L' Osservatore Romano,* 12 February, 2000

Address of Homage

Most Blessed Father,

today in St. Peter's Square are to be found sick people and health care workers from the five continents who are here to celebrate with Your Holiness the Jubilee Day of the Sick and Health Care Workers.

They have prepared for this by engaging in long pilgrimages: they left their places of origin, with all the forms of suffering which derive from having to face up to major journeyings. Yesterday they celebrated the Eucharist in 'St. Pauls Outside the Walls' and today these sick people and health care workers find themselves in this square so that Your Holiness may lead them towards full indulgence, allowing them to find Christ, the centre of history, in suffering and in pain, but also in the health of the resurrection.

The presence of these sick people and of these professionals of health wants to be a canticle of solidarity and of hope in the salvation of the resurrection. They want, in addition, through indulgence, to increase their communion and to be witnesses of Christ, the only way of Truth and Life, as an answer to the very many questions raised by the state of infirmity and illness, both to these people and to the whole world.

The presence of Your Holiness is the highest strengthening of this communion, through our union with the successor of Peter, source of unity and of solidity throughout the Church. We strongly wish that Your Holiness will lead us, with all the force of the Jubilee Year, in this Eucharist, to the only answer that the world can find, faced with the problems of the culture of death, in full openness to the culture of life.

H.E. Mons. JAVIER LOZANO BARRAGÁN,
Archbishop-Bishop Emeritus of Zacatecas,
President of the Pontifical Council
for Health Pastoral Care,
the Holy See

For the Suffering, Christ is the Door to Life

THE HOMILY OF THE HOLY FATHER DURING THE CELEBRATION OF THE EUCHARIST IN ST. PETER'S SQUARE, 11 FEBRUARY 2000

1. "The day shall dawn upon us from on high" (Lk 1:78). With these words Zechariah foretold the Messiah's imminent coming into the world.

In the Gospel passage just proclaimed, we relived the episode of the Visitation: Mary's visit to her cousin Elizabeth, Jesus's visit to John, God's visit to man.

Dear brothers and sisters who are sick and have gathered in this square today to celebrate your Jubilee, the event we are observing is also the *expression of a special visit from God*. With this in mind, I welcome you and greet your warmly. You are in the heart of Peter's successor, who shares your every concern and anxiety: welcome! Today I deeply share this celebration of the Great Jubilee of the year 2000 with you and with the health-care workers, family members and volunteers who are at your side with loving devotion.

I greet Archbishop Javier Lozano Barragán, President of the Pontifical Council for Pastoral Assistance to Health-Care Workers, with his staff, who have organized this Jubilee meeting. I greet the Cardinals and Bishops present, as well as the prelates and priests who have accompanied groups of the sick to today's celebration. I greet the Health Minister of the Italian Government and the other authorities here. Lastly, a grateful greeting goes to the many professionals and volunteers who have made themselves available to serve the sick during these days.

The cross of Christ is the key to understanding suffering

2. "The day shall dawn upon us from on high". Yes! Today God had visited us. In every situation He is with us. But *the Jubilee is the experience of a very special visit from Him*. In becoming man, the Son of God came to visit every person, and for each one he has become "the door": the door of life, the door of salvation. Man must pass through this door if he wants to find salvation. Each person is invited to cross this threshold.

Today you especially are invited to cross it, dear sick and suffering people gathered in St. Peter's Square from Rome, from Italy and from the whole world. The invitation is extended to you who are connected by a special television link-up and are united with us in prayer from the shrine of Czestochowa in Poland: I offer you my cordial greeting and gladly extend it to everyone who is following our celebration on radio and television in Italy and abroad.

Dear brothers and sisters, some of you have been confined to a bed of pain for years. I pray God that today's meeting will bring you extraordinary physical and spiritual relief! I would like this moving celebration to offer everyone, the healthly and the sick, an opportunity to meditate on the saving value of suffering.

3. Pain and sickness are part of the human mystery on earth. It is, of course, right to fight illness, because health is a gift of God. But it also important to be able to discern God's plan when suffering knocks at our door. *The "key" to this discernment is found in the Cross of*

Christ. The incarnate word embraced our weakness, taking it upon himself in the mystery of the cross. Since then all suffering has *a possibility of meaning*, which makes it remarkably valuable. For 2,000 years, since the day of the Passion, the cross shines as the supreme manifestation of God's love for us. Those who are able to accept it in their lives experience how pain illuminated by faith becomes a source of hope and salvation.

Dear sick people, called at this moment to carry an even heavier cross, may Christ be the door for you. May Christ also be the door for you, dear friends who accompany them and care for them. Like the Good Samaritan, every believer must offer love to those who live in suffering. It is not right to "pass by" those who are tried by sickness. Instead, it is necessary to stop, to bend down to their illness and to share it generously, thus alleviating their burdens and difficulties.

The Redeemer bore our griefs and carried our sorrows

4. St. James writes: "Is any among you sick? Let him call for the elders of the Church, and let them pray over him, anointing him with oil in the name of the Lord; and the prayer of faith will save the sick man, and the Lord will raise him up; and if he has committed sins, he will be forgiven" (Jas 5:14-15). We will relive the Apostle's exhortation in a particular way when, in a little while, some of you dear sick people will receive the sacrament of the Anointing of the Sick. By restoring spiritual and physical vigour, this sacrament shows clearly that for the suffering Christ is *the door that leads to life*.

Dear sick people, this is the crowning moment of your Jubilee! In crossing the threshold of the Holy Door, you are joining all those in every part of the world who have already crossed it and those who will be crossing it during the Jubilee Year. May passing through the Holy Door be a sign of your spiritual entry into the mystery of Christ, the crucified and risen Redeemer, who for love bore "our griefs and carried our sorrows" (Is 53:4).

5. The Church enters the new millennium, clasping to her heart the Gospel of suffering, which is a message of redemption and salvation. Dear sick brothers and sisters, you are exceptional witnesses to this Gospel. The third millennium awaits this witness from suffering Christians. It also awaits it from you who work in the health-care apostolate and in various ways carry out a mission to the sick that is highly significant and most appreciated.

May the Immaculate Virgin, who came to visit us at Lourdes, as we recall with joy and gratitude today, bend down to each of you. In the cave of Massabielle, she entrusted to St. Bernadette a message which brings us to the heart of the Gospel: to conversion and penance, to prayer and trustful abandonment into God's hands.

With Mary, the Virgin or the Visitation, let us too praise the Lord with the *Magnificat*, the hymn of hope for all the poor, the sick and the suffering of this world, who exult with joy because they know that God is beside them as their Saviour.

So, together with the Blessed Virgin, let us proclaim: "My soul magnifies the Lord" and turn our steps towards the true Jubilee Door: *Jesus Christ, who is the same yesterday, today and for ever!*

With Thousands of Sick People through the 'Porta Santa' of St. Paul's*

10 FEBRUARY 2000: THE HOLY MASS PRESIDED OVER BY ARCHBISHOP LOZANO BARRAGAN

A long, deep and unending river of pilgrims flowed on Thursday afternoon into the basilica of 'St. Paul's Outside the Walls'. The people who went through the 'Porta Santa', however, were not 'ordinary' pilgrims but the 'privileged people' of this Holy Year – the suffering, the sick, and those who accompanied them, that is to say family relatives or voluntary workers.

Behold the privileged pilgrims! This was how they were called in recent past days by Archbishop Crescenzio Sepe, Secretary General of the Committee of the Great Jubilee of the Year 2000 during the press conference to present the Jubilee of the Sick and Health Care Workers, the celebrations for which were inaugurated on Thursday afternoon by that river of people who took part in the solemn mass in the basilica.

That River of Suffering and Love

Even when the celebration had begun, the flow of pilgrims – on foot, in wheelchairs or in cots – gave no idea that it would halt, flowing into the inside, in the naves, almost an ocean of suffering and of pain but also and above all else of love and of faith.

In his homily Archbishop Javier Lozano Barragán, President of the Pontifical Council for Health Care Workers (of Health Pastoral Care), who presided over this Eucharist concelebration, spoke of this love and this faith. With him the Secretary of the same Pontifical Council, Bishop José Luis Redrado Marchite, and another twenty-three archbishops and bishops, in addition to more than a hundred priests from various parts of Italy and the world, joined in this concelebration.

"Christ is the centre of the convergence of everyone and to him, together, we must all come", said Archbishop Lozano Barragán. "He is the centre which gives us unity and communion: the centre of the history of the whole of humanity and the history of each one of us. To reach Christ we need, however, two actions – the action of faith and the action of love, which are like the feet with which we walk towards this centrality of the Lord Jesus."

The faith of the sick and of their family relatives. The charity of those who accompany them. "To accompany them is like helping one of the family. It is a simple and dutiful answer to someone who calls you, who asks you to lend a hand", we are told by Giusi, aged twenty-five, who has come from Salerno with Unitalsi.

Simple People, Serene People

In the same train there also came Eleonora and Antonio, husband and wife, with their son Antonio, struck by encephalitis when he was only fifteen months old.

He is now thirty-two. He is sitting between them on a bench at the back of the basilica.

These are simple people, tested by life yet at the same time serene. "It is faith which has brought us here", Eleonora tells us, with

a candid and sincere expression which is worth rivers of words.

The faith and the devotion of this crowd which has come from all over the world is borne witness to, in addition to their demeanour, by their expressions, above all by their wish to be reconciled with the Lord.

For the whole of the Holy Mass, along the lateral naves of the basilica, next to the confessional boxes but also in the corners of the church, sizeable groups of people could be seen waiting to engage in confession.

Forgiveness and indulgence, and nothing else, these pilgrims have come to ask for, as Archbishop Javier Lozano Barragán emphasised in his homily. He, instead, asked them to join their suffering to that of Christ, and to offer with him, in communion with Mary, with the saints and the Pope, their pain and their prayer for the salvation of humanity "so that Christ shines with new light in this new millennium", and "so that atheism disappears – a practice which is invading our countries with secularisation".

"May passing through the 'Porta Santa' be for you a move from darkness into light, from hatred to love, from injustice to justice, and from sadness to happiness", also declared the Archbishop.

However, there was no sadness in the faces of those thousands of people. Suffering, certainly, but not sadness, Rather so much light, so much hope, so much love, and so much sweetness.

The Story of Francesca

We met Francesca, who was standing beside a young man in a wheelchair – the gestures with which she looked after him were so affectionate that we thought that they were mother and child!

Francesca is a 'dame of charity', sixteen years old, and has accompanied Antonio to Rome. He is eighteen years old and has been afflicted by spastic tetraparesis ever since his birth.

They come from Sibari in Calabria. "We have been travelling with Unitalsi for two years", Francesca tells us, "for him it is important because before that he never went out of his home. Now he is becoming more confident".

"I came for reasons of faith but also out of curiosity", observes Antonio, who goes to a classical high school. "It is important to meet others who have the same problems as you, both from a human point of view and from a religious angle. I am happy: I went through the 'Porta Santa' and I even met some friends of mine".

We ask him if he feels that he is a 'privileged' pilgrim. "No", he answers, almost deriding the idea. "I feel like everybody else. Of course suffering increases your sensitivity. Above all else it is good to see so many people working for the good of others".

An Important Lesson

But those who really do something for other people, we would like to tell Antonio, are people like him, who suffer but do not disdain to distribute smiles.

This is an important lesson which Silvia and Francesco have also absorbed. They are respectively seventeen and eighteen years old, and we meet them in the basilica. They seem to have carefree expressions on their faces. They have also come to accompany sick people, and they have come from Ancona.

"We have learnt many things", they tell us with a sudden seriousness, "above all to respect other people, and that we, given our good health, are really very fortunate indeed. Their suffering teaches us the real values of life; that is to say, they teach us to live".

ALESSANDRO IAPINO

* From *L' Osservatore Romano*, 12 February, 2000

The Homily of H.E. Mons. Lozano Barragán in the Basilica of St. Paul's Outside the Walls

I extend my greetings to all of you, bishops, priests, professionals of health care, and sick people, who have come from so many countries of the world to meet Christ, source of health, during this Jubilee Year.

There are many elements which accompany us and help us to meet Christ during the Jubilee Year. The most important is that Christ is the point of convergence of all men and that we must all go to him together. As a centre, he is the source of unity and communion. The date that we are celebrating today, the two thousand years since the birth of Christ, reminds us that Christ is the Lord of the history of the whole of humanity and of each and every one of us. The whole of the life which we have passed finds its own horizon, its own centre, its own reason for being in him.

To reach Christ two elements are necessary: faith and love, which can be seen as the two feet with which we walk towards this centrality of the Lord Jesus. In this way, repentant about everything that has distanced us from him, we ask his forgiveness and indulgence. We also need humility to recognise our mistakes and our sins and to ask the Lord that they may be forgiven. We also practice the virtue of hope as something which is specifically Christian – we take refuge in the mercy of God trusting in the merits of Christ, through whom the merits of the Most Holy Virgin and the Saints acquire value. We ask God to apply these merits to us in order to obtain our full love for his forgiveness.

We have very great faith in the mediation of the Church so that our poor persons, needful of forgiveness and indulgence, can be participants in the merits of Christ, of the Most Holy Virgin, and of the Saints. We know that the Lord Jesus entrusted his apostles, led by Peter, with the power to forgive sins in his name, and that this power has been exercised in an alive way during the course of the whole of history, and that this will be the case until the end of the world through the bishops, guided by the Pope, as the successors of the apostolic college. We believe in the Church which is one, holy, Catholic and apostolic, and trusting in this apostolic nature, we come to the Seat of Peter so that the Pope himself can enable us to obtain the grace of mercy and complete forgiveness.

This is the meaning of our pilgrimage. We have come resting ourselves on our two special feet, those of faith and love, of charity, and after much effort and trial, given our special condition, we have reached the Porta Santa. We have passed through it to show that we have passed from the darkness into the light, from hatred to love, from injustice to justice, and from sadness to joy, and we have reached the tomb of the apostles in this basilica of St. Paul's Outside the Walls to obtain, by their intercession, full and complete indulgence. We will repeat this action tomorrow in the basilica of St. Peter's in the presence of the Holy Father John Paul II.

We have passed from sadness to joy. We realise that this suffering of ours, our pains, united to those of Christ in his passion and glorious cross, are not elements which are negative. Rather, Christ himself has taken them upon himself and transformed them into something positive, a source of joy, of redemption, and of resurrection. Our trials have been transformed in this pilgrimage of the Jubilee Year into a source of life. The aim of this pilgrimage of ours has involved passing

through the Porta Santa, and this has meant to move from death to life. Such, then, is the full and complete indulgence to which we aspire – to always live in fullness of health, even when we are in pain and suffering.

Within the Church there exists what we call the Communion of Saints. That which everyone does in life which is good, in virtue of the merits of Christ, becomes a source of salvation for others. This takes places thanks to the merits of the Most Holy Virgin Mary, of all the saints, and also of all of us, and especially the sick. We live in close communion and unity with the Church. This is the one and holy Church, in her universality and Catholic nature, which, thanks to the apostolic force, is transformed for everybody into a source of salvation, naturally enough beginning with Christ, the one and only Saviour.

Today, in this vigil of prayer, I exhort all of you, and in particular those who are sick, to offer your sufferings and your pain to Christ so that he may take them upon himself. Indeed, he has already taken them upon himself, and beginning with them, he extends his graces to all of you and to the whole of the Church. These gifts are forgiveness for the pains suffered for our sins, and they allow us to draw near lovingly even more to Christ in order to receive, thereby, full and complete indulgence.

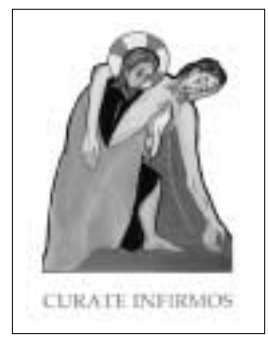
We have said that the fundamental steps to take to ensure that our pilgrimage bears fruit are faith and love, charity. Indeed, through them we can affirm that Christ is the source of our union, our communion, horizon, and centre. For this reason the Pope invites us to offer our suffering and our Jubilee prayers for two well-defined ends – so that Christ can be preached where he is not yet known and so that there is freedom to practice the Christian religion throughout the world. At this moment we offer all our trials, our suffering, and our pains so that Christ may shine with new light in this millennium which is beginning, so that everywhere a new evangelisation may take place; so that practical atheism, which is invading so many of our countries with secularisation, can be ended; so that the whole world may recognise that there is no other saviour than Jesus; and so that all man may exercise their fundamental right to believe in him and behave accordingly in all the contexts of their lives. We need to bring Christ into such different areas as the economy, politics, culture, and the whole of society. Our prayer during this Jubilee Year is that our illnesses, our suffering and our pain, may become springs from which there comes real life for the whole of mankind.

May the Most Holy Virgin, the great Porta Santa of the history of salvation, help us to pass through this door to encounter her Son Jesus Christ, medicine of all our illnesses and treatment for all our pains! In this Jubilee Year we will thus find Christ the Divine Physician who gives us happiness.

H.E. Mons. JAVIER LOZANO BARRAGÁN
Archbishop-Bishop Emeritus of Zacatecas,
President of the Pontifical Council
for Health Pastoral Care.
The Holy See

Jubilee Day of the Sick and Health Care Workers

'Health Care Workers and the Challenges of the Third Millennium'



The Congress of the Bishops Responsible for Health Pastoral Care, and Catholic Associations Engaged in Health Pastoral Care

9 February 2000
The New Synod Hall
The Vatican

Speech of Greeting to the Joint Conference of Professionals of Health

Within the context of the celebrations of the Great Jubilee of the year 2000, I have great pleasure in celebrating this conference which is of great importance for all professionals of the world of health. I would like to express my cordial welcome to all of you: bishops, medical doctors, male and female nurses, pharmacists and voluntary workers. I wish and hope that our meeting will bring to all of you one of the most important fruits for the health care ministry, as a beginning to this third millennium.

In this conference we will work in the same spirit as the Jubilee, whose aim is to place Christ at the centre of history, of times, and of the cosmos. The form that we will follow for a real and authentic health care ministry will be that of placing Christ at the centre of medicine in all its expressions. Faced with the questions and difficulties which now affect the various categories of health care professionals and which are often the consequences of the globalisation of the economy, we propose a new model of medicine whose goal, end and horizon are Christ alone.

It is within this trajectory that we have located the subject of this conference: the identity and the challenges which are faced during the new millennium by those responsible for the health care ministry, medical doctors, and pharmacists, all those, that is to say, who in one way or another, are concerned with this sector which is so important in the life of today's world.

Given the complexity of the subject, the deliberations of the conference will, with the help of God, be organised in two parts – one which is analytical and one which is summarising. During the first we will divide ourselves into groups so that each sector of professionals

can study, in particular, its own questions and issues and offer those solutions which it thinks are most suitable; during the second we will meet for an exchange of the various solutions which have been proposed and to achieve an overall vision.

Bishops, priests, medical doctors, male and female nurses, and pharmacists – each of these categories will have a separate place to study the subject matter with which it is concerned. The method which we will follow will be very simple – meetings which will outline the question and indicate relevant solutions, and discussions within the same group in a sort of forum. In each group there will be a secretary who will write down what has emerged during the discussion and then present it during the second part of our meeting. In this way the whole of the assembly will be able to know the results of the studies of each sector of the various professions of the field of health and the intended overall vision will thereby be achieved. We wish and hope to be able subsequently to produce a publication of this first general study of the health care ministry to be engaged in during this millennium, and the results will then be available for use within the Church.

As you yourselves are probably aware, the presence of people at this conference is based on selection. All of you come in your own names, it is true, but at the same time you also represent the other professionals of the health care sector of which you are a part. And it is through you and your various different organisations that the results of this conference must reach all the other members of your various professions. You thus bear the responsibility for many other people who have not been able to be present at this conference, even though they wanted to attend, because for reasons of space it was not possible to extend the invitation to a greater number of people. Your presence is thus a very qualified one, and this places you in a position of great responsibility with regard to the evangelisation of medicine in the specific place in which you work and practice your profession.

May the Most Holy Virgin, the great 'Porta Santa' through which Christ came into the world and through whom we pass in order to reach him during this Jubilee Year, accompany us during this first act of our Jubilee Day of the Sick so that we may place Christ at the centre of all our lives, both at a personal level and in the profession to which we belong, in order to offer to today's society a light on how to reach full health in a world in which harmony is often destroyed and solidarity profoundly wounded, having the effect, in particular, of marginalising those who are most poor and the sick!

H.E. Mons. JAVIER LOZANO BARRAGÁN,
Archbishop-Bishop Emeritus of Zacatecas,
President of the Pontifical Council for Health Pastoral Care.
the Holy See

National Episcopal, Diocesan and Parish Co-ordinating Bodies for Pastoral Care in Health*

The Goals and Workings of Co-ordinating Bodies for Pastoral Care in Health

First of all, there must be a clear definition of the real nature of a national episcopal co-ordinating body for pastoral care in health, and this definition must begin with an awareness of its goals and ends. Such a body must express the care and concern of the Church for the infirm because it is concerned with health care workers and their pastoral action. It must know that this action is motivated by compassion and should want such compassion to meet the new needs which arise in an ever more effective fashion.

The co-ordinating body for pastoral care in health, therefore, will have health care workers as its targets, and in order to summarise the action which it must engage in, it may be said that its goals are as follows: *to express the care of the Church for the infirm and help those who serve the sick and the suffering so that the apostolate of compassion which they seek meets new needs in an ever more effective way.*

The question arises as to how this should be put into practice. To this we can respond with four programmes of action under the headings of doctrine, co-operation, promotion, and accompanying.

1. Doctrine

The co-ordinating body for pastoral care in health must have first and foremost a doctrinal task – it must inform people about the Christian meaning of health, illness and human pain, and it must do this by taking into consideration the new times in which we live.

a. Health

Physical, mental, social and spiritual wellbeing are of fundamental importance for the Christian concept of the health of the human person in the performance of the mission entrusted to that person by God, a mission which changes according to the individual's stage of life.

The work of health care workers, therefore, must be directed towards ensuring that each person has that health which is necessary to the fulfillment of his or her mission during that stage of his or her life which is being being led at that particular time.

b. The Meaning of Pain

Pain must be seen and experienced from the starting point of the pain of Christ. Christ redeems through pain and releases us in definitive fashion from it. We know that this is the meaning of his redemptive death and resurrection.

The projected co-ordinating body for pastoral care in health must illuminate the real concept of health in the light of the pain experienced by Christ, and provide it with that perspective which is not to be found in contemporary secular approaches to the subject.

c. Adjustment to the Times

The pastoral activity of the health care worker must be adjusted to the times. Nowadays there are a vast number of problems and difficulties which require suitable solutions. Reference can be made here, for example, to the impact of globalisation and its consequences for pastoral care in health. At this point only three contemporary questions will be examined, questions which are of immediate importance for those people who are active in the field of pastoral care in health. These three questions are: the socialisation of health, bioethics, and health education.

c.1. The Socialisation of Health

The action taken by pastoral care in health changes according to the context of the social policy of each specific country which is practiced towards the sick person. There are countries where such action primarily involves the provision of basic health care to sick people in their homes or in private or Catholic hospitals. In other countries such action chiefly involves the organisation of the best forms of assistance possible for sick people in government-administered health centres. And in yet others emphasis is placed upon providing help to sick people in their homes after they have been discharged from health centres or similar institutions.

c.2. The Bioethical Aspect

With regard to the question of the origins of life, the basic principle continues to be that human life is a gift of God and should be treated as such. The way in which God wants this gift to be transmitted is in the highest form of love, that is to say the conjugal love of two marriage partners within the family. Everything that contradicts this principle is unacceptable from a moral point of view.

The same principle applies to euthanasia. Life is a gift of God and as a consequence man cannot take it from another innocent man.

c.3. Health Education

People must be educated to embrace the cause of humanisation and of quality of life – the so-called "QALYS" (quality adjusted life years system). We understand the concept of QALYS in the following way: in meeting the need for quality of life one must take into consideration not only the quantity of years that a person lives but also their quality, and this quality is assessed not only in terms of the economic resources which are available but also in relation to those resources of a family, environmental and spiritual etc. character which make life useful for the individual himself or her-

self and for those around him or her – a life which successfully performs that mission which has been given to it by God.

2. Co-operation

The national co-ordinating body for pastoral care in health should co-operate with the local Churches and in the dioceses, and must provide spiritual assistance to health care workers, not least by supplying them with the necessary forms of relevant support and back-up.

These are the principal health care workers:

a. The Parishes

In order to be effective in practical terms, pastoral care with reference to health care workers must be organised within the local parish itself. What has already been said in this paper about doctrine, co-operation, promotion and accompanying in relation to pastoral care in health must be put into practice in ways which are suited to the specific character of each individual parish.

b. Catholic Hospitals

The criteria to be employed to decide whether a hospital can really describe itself as being Catholic or not are as follows: whether it continues or does not continue the healing ministry of Christ in today's world; whether or not it expresses the Magisterium of the Church in its provision of overall pastoral care in health; and whether or not it is accepted as being a Catholic hospital by the relevant ecclesiatical authority (cf Can. 300). The Catholic hospital must accept the Magisterium of the Church both in relation to health and health care questions in the narrow sense – and in particular with regard to the beginning and end of life – and in relation to economic issues as a whole.

c. Hospital Chaplains

The figure of the hospital chaplain or of the chaplain who belongs to any other kind of health care centre is becoming increasingly important. Whereas previously the chaplain confined himself to pastoral care in the sacramental sense of sick people, it is now the case that he provides a Christian meaning to health and illness and is concerned with all the questions, issues and difficulties which are connected to this meaning. This is done at the same level and in the same area as all the other health care workers: medical doctors, nurses, hospital administrators, pharmacists and so forth.

d. Female Members of Religious Orders

The responsibilities of male and female religious are becoming increasingly difficult in the hospital world, and in some countries the vocations in the sphere of pastoral care in health are decreasing. However, today more than ever before it is necessary for male and female members of religious orders to be present in these places, both because the spiritual approach in the health field is gaining new ground and because the secularisation of the world of medicine is something which is becoming increasingly acute.

e. Medical Doctors

Catholic medical doctors are organised at both an international and a national level. We must help them to strengthen their union. They are agents who are of determining importance for pastoral action in the world of health and health care. They must recognise and uphold medical ethics to the full and their work must go beyond the mere exercise of a profession. Their mission is to be heralds of the culture of life in the face of the devastating currents of the culture of death, and this is especially the case with regard to the medical questions and issues raised by genetic engineering and euthanasia.

g. Male and Female Nurses

Nurses play a very important part in pastoral care in health, and this is especially true today when we have before us the abandonment by female religious of the world of hospitals. It is therefore nurses who should shoulder the responsibility for pastoral care provided to patients during the daily routine of hospital treatment and medical care. The ethical and professional training of Catholic nurses is of the very greatest importance and should be promoted by the various bodies active in the field of pastoral care in health which are to be found in the episcopal conferences.

h. Pharmacists

The Catholic pharmacist has a very great role to play when it comes to the provision of suitable drugs and medicines. He or she also has important responsibilities with regard to the control and supervision of drugs and medicines, especially in the case of chemical precursors and synthetic drugs.

i. Voluntary Workers

Today there are many other kinds of pastoral workers in health in many parts of the world and they are called Christian health care voluntary workers. These are real apostles of compassion towards the sick.

j. Health Care Authorities

When dealing with the area of health care authorities, reference must be made in each country to that country's Ministry of Health. Where possible or where opportune the Church must have a representative who co-ordinates her pastoral action, or at the very least the relations which exist between the national co-ordinating body for pastoral care in health and this Ministry must be of such a character as to promote the inculturation of the message of the Gospels in the implementation of health care policies.

Subsidiarity

The function of the national episcopal co-ordinating body for pastoral care in health must be to serve and help the various dioceses and thus the various bishops as well. Its function, therefore, should not be to take the place of pastors in the discharge of their duties in the dioceses, but rather to help and support them. We can thus affirm that its work should be of a subsidiary character and that the help which it supplies must involve the promotion, co-ordination and direction of pastoral care in health in every diocese.

3. Promotion

The co-ordinating body for pastoral care in health must help and support national Catholic organisations which are in-

volved in pastoral care in health in both their theoretical and their practical activities.

a. Foundations and Sanctuaries

It is very important to encourage relationships with foundations which can finance, or offer patronage to, work which should be performed, and the same may be said of sanctuaries, and especially Marian sanctuaries – institutions which have a special relationship with the sick and which can help people in both a spiritual and economic sense.

b. Faculties of Medicine

A national co-ordinating body for pastoral care in health should play an orientating and directive role with regard to the Catholic faculties of medicine in its own country. The same directive function is also needed with regard to the committees for bioethics – organisms which are greatly growing in number at the present time.

c. Other Organisations

Organisations such as the Red Cross, for example, must learn that they have the support of the national co-ordinating body for pastoral care in health. The same may be said for the other organisations which directly promote or direct health care centres or institutions, such as Caritas or certain special foundations.

Support:

Support for these institutions means promoting and co-ordinating where possible – and directing according to the ecclesial Magisterium – not only the faculties of medicine of universities but also other institutions. This direction can take place by fostering a dialogue between them and the national co-ordinating body.

4. Accompanying

The national co-ordinating body for pastoral care in health should follow scientific and legislative innovations in order to illuminate them from the starting point of the pastoral action of the Church in the health care field.

a. Legal Aspects

The action of the national co-ordinating body must also address itself to the faculties of law of the universities – and in particular to those which belong to Catholic universities – in order to train and instruct the legal conscience of future lawyers who will work in the medical field.

b. Scientific Aspects

The centres of bioethics require special attention because of their research, the results of this research which are offered to the general public, and the approaches and orientations which accompany such results. Here what has been said about the legal aspects of parliamentary bills on the subject, for example on cloning, comes into play. The experiments carried out in laboratories and the questions and issues raised by drugs and medicines – particularly those created by laboratories – are of special importance.

c. The Socialisation of Health Care

Another question which has already been referred to in this paper is that of the socialisation of health services. The envisaged national co-ordinating body must pay especial attention to the practical expression of such socialisation in each country. It must strive to resolve the bureaucratic problems involved in this process of socialisation and open up the road to a greater efficiency which, where this is possible, can avoid the pitfalls of bureaucracy.

d. Emerging Illnesses

In each country there must be a clear awareness of what these pressing scourges are. In some places one is dealing with malaria, in others AIDS, and in others drugs, leprosy, tuberculosis, cancer, excessive smoking and so forth.

Conclusion

In this paper an attempt has been made to offer certain ideas about how to define the goals and workings of a national co-ordinating body for pastoral care in health acting within an episcopal conference, and in suitably adjusted fashion to do the same with regard to similar bodies acting within dioceses and parishes. Just as the function of this Ministry is to achieve ecclesial communion in the sphere of pastoral care in health, so the objective of every national episcopal co-ordinating body for pastoral care in health should be the promotion of this communion in this field by the local Churches, and these latter should act as a support for the pastoral care provided by the dioceses.

As will have been noted, this paper has sought to establish an analogy between the Pontifical Council for Pastoral Assistance to Health Care Workers and episcopal co-ordinating bodies for pastoral care in health at national, diocesan and parish levels, and has done this with full awareness of the need for variations in their character according to the level at which they operate. These are suggestions and guidelines which have been made for episcopal conferences. Each conference must find the most effective way by which to establish its own co-ordinating body, and every diocese must do that which it believes to be most opportune for its own situation.

H.E. Mons. JAVIER LOZANO BARRAGÁN
President of the Pontifical Council for Health Pastoral Care

***** This text is made up of selected parts of the article by H.E. Mons. Lozano Barragán which was published in *Dolentium Hominum* n.41/II-1999.

The Pontifical Council for Health Pastoral Care 1985-2000

1. What is the Pontifical Council?

1. An important date. 11 February 1985 is an important date for the Church, for the sick, for religious institutions, and for all health care workers. By the Papal Motu Proprio "Dolentium Hominum", His Holiness John Paul II established the Pontifical Commission for Pastoral Assistance to Health Care Workers. Three years later, with the reform of the Roman Curia (C.A. *Pastor Bonus*, 28 June 1988), this Pontifical Commission became the Pontifical Council for Pastoral Assistance to Health Care Workers, obtaining thereby the autonomy that an Apostolic Constitution gives to all the Ministries belonging to the Roman Curia.

2. *The motivations that lay behind the Pope's creation of this Ministry*. The Apostolic Letter indicates, amongst other things, the following motivations: the care and concern of the Church for the man who suffers, the great advances achieved by medicine, and the need to co-ordinate all the bodies which dedicate themselves to the world of health because individual action on its own is not enough. Hence the need for joint, intelligent, planned, constant and generous work.

3. *Tasks*. The principal tasks entrusted to the Pontifical Council are the following: to foster, promote, co-ordinate, and co-operate with the local Churches and carefully follow health care programmes and their consequences within the context of the pastoral care of the Church.

4. *Organisation*. The President: H.E. Mons. Javier Lozano Barragán; the Secretary: H.E. Mons. José L.Redrado O.H.; the Under-Secretary: Rev. Felice Ruffini, M.I. The Council has thirty-four Members who represent the different Ministries of the Roman Curia and religious health care institutions. There are also forty-eight Consultors and a Secretariat made up of a number of Officials and a group of voluntary workers who are present during office hours.

2. The Activity of the Pontifical Council

a. The First Stage, 1985-1996: Twelve Years of Activity

This is a period which covers the birth of the Pontifical Council, a stage of creativity and the first initiatives at the level of organisation.

The creativity was immense under the presidency of Cardinal Angelini. The Pontifical Council was a new instrument. With regard to the institution and its functions, it was a matter of beginning from scratch. The salient features of these early years were: the setting up of the review *Dolentium Hominum* to be published in four languages; a large number of journeys abroad to learn about health care and pastoral realities in foreign countries; taking part in various congresses; the international conference organised by the Pontifical Council – a platform for health care and pastoral culture; the World Day of the Sick; close relations with the local Churches, with the fostering of structures for the health care ministry within them; visits *ad limina*; relations with the World Health Organisation (WHO) and other such bodies; the publication of books and pamphlets which could act as instruments of work and stimulation; and lastly, the intense and increasing activity of the Secretariat. These were years of fruitful work, years, we could say, when foundations were established and roads opened up, years in which important goals were reached for the health care ministry within the universal Church.

The work was the fruit of inspired leaders who were its engine, but also of all those who worked day by day carrying out their mission with effectiveness and efficiency. We refer here to all the staff of the Secretariat, to the Members, to the Consultors, to the Experts, and to the voluntary workers. All of them, with prestige, effectiveness, efficiency and intelligence made possible the immense work of this first stage of the Pontifical Council.

b. The Second Stage, January 1997...

This second stage covers the period of the changeover in presidents: H.E. Mons. Javier Lozano Barragán took the place of Cardinal Angelini. The new president followed the work which was underway with great attention. The Plenary Assembly of the Ministry was held on 9-11 March 1998. All the Members and some of the Consultors took part in this meeting. The fruit of this IV Plenary Assembly was the new work plan of the Pontifical Council for Pastoral Assistance to Health Care Workers, a valuable instrument for the daily work of the Ministry. This work plan was approved by the Holy Father and included forty-seven programmes organised around the ministries of the Word, of Sanctification, and of Communion, and which were entrusted to the eighteen individuals who make up the Pontifical Council: Superiors, Officials, and collaborators. In order to ensure that it was known about, this work plan was published and distributed to the heads of the Ministries of the Roman Curia, to the Episcopal Conferences, and in particular to bishops responsible for the health care ministry.

Through this new planning of its work, the Pontifical Council wanted to respond in a more effective way to the mission entrusted to it by the Holy Father – to be a help to his valuable Petrine ministry in the specific field of health and of health care.

In the drawing up of the work plan the point of reference employed was the original Motu Proprio *Dolentium Hominum* which established the Ministry,

and the Apostolic Constitution *Pastor Bonus*. It thus also thereby referred to the Christian meaning of suffering and life, the Apostolic Letter *Salvificis Doloris*, and the Encyclical *Evangelium Vitae*.

In formulating the practical directions and concerns of the general work plan, particular attention was paid to the suggestions and the observations made by the Apostolic Letter *Tertio Millennio Adveniente* and by the *Charter for Health Care Workers*.

Beginning with these doctrinal premises, the Pontifical Council drew up its own work plan with reference to four key elements: its purpose, its policies, its forms of action, and its programmes.

The Purpose of the Ministry

On the basis of what has been described above, the general goal of the Pontifical Council was established with particular reference to this time of the Great Jubilee of the year 2000, and that general goal was as follows: "to commemorate the Incarnation of the Word in line with the Bull "Incarnationis Mysterium", to enlighten health care cultures with the Gospel, to sanctify the sick person and the health care context in general, and to achieve the unification of health care throughout the world in the whole Church".

The Work of the Ministry

Regarding the practical level, in order to reach this goal, and taking into account the specific objectives of the ministry of the Word, which contains eleven programmes, the Pontifical Council established the following objective: "to commemorate the incarnation of the Word by enlightening health care cultures through the signs of the Jubilee: Pilgrimage, the Holy Door and Indulgence."

In relation to the ministry of sanctification, which has seven programmes, the objective was the following: "the sanctification of the sick person and of the world of health in general through the three signs of the Jubilee: Pilgrimage, the Holy Door, and Indulgence."

In relation to the ministry of communion, which has twenty-nine programmes to be implemented, the objective was the following: "to obtain the unification of the health care ministry throughout the world through the sings of the Jubilee: Pilgrimage, the Holy Door and Indulgence."

In order to achieve the goal established by the Ministry with regard to the ministry of the Word, the following initiatives were taken: an attempt was made to promote the meaning of life and suffering, and the meaning of nature and its manipulation, by explaining them, spreading and publicising them, and making them known to everybody, in particular to bishops during their *ad limina* visits or temporary visits to Rome. In this area great help was obtained by the celebration of the XIV international conference held by the Pontifical Council, the publication of the review *Dolentium Hominum*, the participation of the Officials of the Ministry at various congresses and meetings, *ad limina* visits etc.

With respect to the evangelisation of faculties of medicine, the Pontifical Council always tries to be in contact with the most important Catholic faculties of medicine, of pharmacy, and of law, with a view to promoting specific courses in the future. The other programmes promoted with great care in the sector of the Word concerned the following areas: publications, the World Health Organisation, the pastoral handbook for drug-addicts, pastoral guidance in health matters, conferences, the international conference of the Pontifical Council, research, teaching centres, and special "dossiers".

The above mentioned forty-seven programmes were implemented with great care by all the component parts of the Ministry. The results were very satisfactory and confirm that the planning of the work matched the objectives fixed for 2000.

To conclude, we would like to mention certain relevant features of the activity of the Ministry carried out during the course of 1999 and the first part of 2000.

1. The celebration of the World Day of the Sick in the Lebanon on 11 February.
2. A large number of inter-Ministerial meetings in which the Superiors or the Officials of the Ministry took part.
3. Participation at various congresses and meetings: of the WHO, Unitalsi, the Academy for Life, on AIDS (Argentina), in Morocco, Poland, etc.
4. Visits by *ad limina* bishops to the Ministry.
5. Various congresses organised by the Ministry:

* 1-2 July: on Catholic hospitals;
* 18-20 November: the international conference on "the economy and health";
* 22-23 November: the symposium on Catholic chaplains in hospitals;
* 9-11 December: the symposium on AIDS;
* 15 January 2000, Symposium of the Leper;
* 7-12 February 2000, The Great Jubilee of the Sick;
* 28 March 2000, The Great Jubilee of the Dentists;
* 4 April 2000, International Congress, Healing the Body and Saving the Soul;
* 6 April 2000, Second Annual Pan-American Catholic Healthcare Dialogue;
* 2-3 June 2000, Symposium, the Sacraments in Pastoral Healthcare.

6. Publishing activity, which centred around the publication of the journal of the Pontifical Council, *Dolentium Hominum*, in four languages. And for the Jubilee World Day of the Sick, the book *Curate Infirmos.*

Of course behind all this activity there lies the daily, and always intense, work of the Secretariat.

H.E. Mons. JOSÉ L.REDRADO O.H.
Secretary of the Pontifical Council for Health Pastoral Care

Catholic Doctors' Challenges and the New Millennium

1. Changes in medical profession

The medical profession has changed tremendously during the last fifty years of the 20th Century. This has been due, in part, to the revolution imposed by the expanding knowledge in biomedical sciences and, in part, to the dramatic changes in society, which could not be without consequences for medical doctors.

a. The increase in scientific knowledge in biomedical sciences and the process of hyperspecialization

The increase in scientific knowledge in biomedical sciences continues at an expanding pace. As a result, the number of medical journals has increased to the point that the impossibility of reading the entire scientific production, even in very specific areas, is taken for granted and there is a proliferation of journals offering abstracts or short versions of the full articles, on paper or on line. Certainly, this is not the single cause of the process of hyperspecialization that is modifying the medical profession, but may be one of the most important, together with the idea that, working as a specialist, it is possible to make more money, compared with general practitioners.

Hyperspecialization is transforming the medical profession, substituting the holistic approach, i.e. the approach that takes care of the person entirely, including his physical, mental and spiritual needs, to a practice based on organ pathology. This long lasting development influences medical schools also, where internal medicine has been fragmented into a series of teachings based on organ pathology. The process seems to have no end, since it also affects specialist disciplines, in which academic success is often secured by the ability of the doctor to further specialise in uncovered fields, trying to become the number one of a little domain.

There is a joke, defining the specialist as the doctor who knows more and more on less and less things, to the point of knowing everything about nothing. Of course, this joke contains a paradox, but certainly also a fair amount of truth.

It is not surprising that medical students are often unable to consider the patient as a unit of body, mind and soul, but have instead a distorted vision of a mere assemblage of organs and tissues. A vision that is reinforced by the undoubted successes of transplant medicine, which urge us to wonder where the principle of unity regulating that organ assemblage is located.

The rate of increase in scientific knowledge is so fast that there is no time to metabolise it and nobody seems to be able to attempt the organisation of the new items of knowledge into a harmonic and coherent picture.

b. The technological invasion of medicine

The second part of the 20th century has also been the era of the technological invasion of medicine. A realm of measurable events has substituted the old medical art, made up of observational abilities, skilful hands and wisdom. As a result, the access to technology is the most important requisite conditioning success.

Technology is a crucial element, undermining even the budgets of economically developed societies and discriminating people of different countries in terms of their right to have access to high quality standards of assistance. Of course, technological development has certainly created new wonderful possibilities for better diagnoses and treatments.

However, apart from the ethical dilemma, posed by technology, as for example in the field of artificial reproductive technology, some doctors unconsciously got the wrong message that it was possible to solve most of the problems of the patient by simply depending on machines. Thus, communication with the patient has been considered less and less important, even with regard to the establishment of personal histories and physical examination, thereby losing great opportunities for using communication as a therapy in itself.

The extreme of this anonymous and impersonal approach of the patient-doctor relationship is shown by the increasing number of web pages where patients can have access to present their complaints and receive suggestions for diagnostic procedures and pharmacological treatment. Internet is a wonderful instrument by which to facilitate communication between doctors living in different parts of the world. In addition, it is a magnificent tool for continuing medical education, with possibility of access to major libraries and journals, the only limitation being time (the joke says that Internet is an instrument for insomniacs and the unemployed). On the other side, communication through computers certainly cannot be considered as a substitute for the tête-à-tête encounter between patient and doctor, despite the real business that is behind this kind of operations.

c. The expansion of the alternative medicines

It is not surprising therefore that an increasing number of people are turning their backs on impersonal medicine and search for relief to their complaints in so-called alternative medicines.

In a society that has expelled traditional faith, the heritage of centuries and the fundamentals of modern civilisation, we observe an invasion of sects, magicians and vague new age spiritualism. The same is happening to medicine. More and more people are turning their backs on cold and impersonal medicine, which is unable to take care of the patient in all his dimensions, and prefer kinds of interventions that, despite any evidence of real effectiveness, nevertheless show an almost sacred charisma. Pranotherapy, Tibetan medicine, herbs and powders of pre-Columbian cultures, healing powers: very different approaches, unified by the fact that the specific therapy is less important than the contact with the therapist, who is endowed with a special healing flow.

The invasion of alternative medicines should raise important questions for medical doctors, who should ask themselves why they have lost charisma and how they have lived their relationship with patients. Instead, very often there is only a manifestation of rationalistic disgust, typical of the man of science closed in his ivory tower. The same attitude is sometimes manifested towards new professions, like for example chiropractors, or acupuncturists, despite the fact that their modalities of intervention are much more understandable for those who have received traditional medical education.

d. The patient's autonomy and freedom of choice

Continuing our reflection on the changes in the doctor-patient relationship, two more aspects need our attention. First, there is an increased request for freedom of choice by our patients. This is not only in the case of immoral procedures, like abortion, or in the case of the refusal of common practices by certain minorities, such as hemotransfusion by Jehovah's witnesses, but also in cases where the patient selects modalities of treatment that are not sufficiently validated by scientific research. This is likely to happen especially in the care of chronic disabling pathologies, in which current treatments are not able to stop the progression of the disease and are the cause of very severe side effects, as in the case of many types of cancer and of multiple sclerosis.

Last year Italy was agitated by demonstrations of oncologic patients and their families, requesting the possibility of deciding a treatment alternative to standardised chemotherapy. I refer to the case of the so-called Di Bella Therapy, which was largely diffused by the media. This alternative therapy was requested on the basis of anecdotal cases and Dr. Di Bella's charisma, despite the lack of any solid scientific evidence of efficacy. Under the pressure of the demonstrations, the government was compelled to authorise payment for the unorthodox therapy by the National Health Service. The Di Bella case showed, on a national wide basis, that the asymmetric relationship of the doctor with his patient had ended and that paternalism had been substituted by the patient's autonomy.

e. The conflict between patient and doctor

This brings us to a second aspect. If paternalism was certainly wrong, autonomy runs the risk of degenerating into frequent conflicts. In fact, mutual trust is increasingly substituted by legitimate suspicion, with the patient and the doctor considering each other a potential enemy. Medical intervention should be effective under any circumstance. The consequences are the enormous business of insurance, the transformation and perversion of the forms for informed consent, from instruments for correct information into bureaucracy for the protection of the doctor. In my country, a so-called Tribunal for the Rights of the Patient is active in every hospital. The name "Tribunal" is self-explanatory about the underlying mentality.

f. The allocation of resources

These are some of the changes at the level of the patient-doctor relationship. Our profession, however, is also challenged by external factors, the most dramatic one being probably the increasing emphasis on the limitation of resources.

f.1. The limits of resources in affluent societies

Needs and resources are the heart of the economic relationship in health policy, but they are characterised by an internal tension that can lead to a difficulty of choice, to an impasse. On the one hand, it is clear that health has a cost, but, on the other hand, health is a priceless possession. For this reason, health pressure can be potentially subversive for an economic system, since it tends to spend the most, to satisfy the maximum of needs.

To bypass the obstacle, health authorities have been limiting the role of public finances in health assistance: the welfare state has been criticised and is under revision all over the world. However, once the budget becomes the most important concern, new moral issues come to our attention.

Affluent societies permit the scandal of having a large part of their population without coverage of basic health needs. The value of human life can come to depend on age, with the access to expensive procedures denied to elderly people. Free access to certain expansive diagnostic procedures can become so restricted in reality that whenever the examination is urgent, the patient is *de facto* compelled to pay and therefore discriminated according to income.

f.2. The lack of resources in developing countries

If this is happening to health systems in post-industrial societies, in the developing countries we continue to witness biblical calamities afflicting poor societies, devastated by maternal and infantile mortality, malnutrition, old and new infections, without local resources to be used for health assistance and with external aid conditioned by the acceptance of programs for birth control, while pharmaceutical companies have no interest in producing drugs to cure the diseases of the poor.

f.3 The medicine of desires

On the contrary, in affluent societies, for those who can afford the costs, there is the explosion of a kind of medicine based on personal desires.

Aesthetic surgery, sex changes, cosmetic dermatology, strange dietetic regimes are examples of a medicine based on desires. Doctors agree to be involved with procedures that have little to do with the relief of human sufferings. The contradiction becomes even more striking when systems compelled to limit the health services offered to the general population nevertheless continue to reserve part of their budgets to the satisfaction of personal desires. In this very city of Rome, the quality of oncologic assistance outside hospitals is rather insufficient and patients are told that resources are insufficient to improve the service. However, you can change your sex at zero cost in a public hospital in Rome.

f.4. The Evidence Based Medicine (EBM)

The problem of the allocation of resources is not only at the macroeconomic level, but it involves the physician in his personal activity too. To give just one example, it is more and more common to hear about so-called Evidence Based Medicine. This is in part the attempt of the scientific community to found medical profession on solid bases, explicating the criteria of behaviour. Peer reviewed publications and experts' opinions, after discussion and consensus conferences, lead to the production of diagnostic and therapeutic protocols or guidelines. These are created by medical doctors for other medical doctors. However, guidelines and protocols are more and more often produced also by health authorities, for example to direct medical profession according to the availability of resources. This leads to an increasing pressure upon medical doctors, with possible limitations on their diagnostic or therapeutic freedom.

g. The end of the centrality of hospitals

The limitation of resources for health systems in affluent societies is pushing in the direction of a giant trend that will change the idea itself of western medicine, based on the centrality of the hospitals. The hospital is no longer the house of hospitality, it is becoming only a place for the diagnosis and treatment of acute diseases that cannot be dealt with in an outpatient clinic.

Nursing homes, residential homes, and rehabilitation centres are considered to be more convenient than hospitals for the care of chronic and disabling diseases, which therefore are pushed out of the hospital. Emphasis is placed on the advantages of bringing medical and nursing assistance directly into the patient's home, forgetting the difficulties experienced in the assistance of chronic patients by today's fragile families, exposed to rupture, with few or no children and with no adults at home. More and more often in the future we will be confronted with a situation of people in need living completely alone, but our medical schools continue to pay very little attention to educational programs focused on chronic disabling diseases with a strong social impact.

Particular attention will be requested by the centres for palliative cares, where only the presence of people who love life will be able to offer a meaning to the death of people alone with their disease.

h. Ageing and denatality

The explosive combination of ageing and denatality may provoke the financial collapse of health systems and modify the type of patient and the clinical problems that the physician will meet in the near future. Despite the general consensus about the risks, not only medical, of an old society without children, the aggression towards life at its beginning and at its very end continues, following the trend inaugurated in the second part of the 20th century with mass contraception, with legislation on legal abortion in many countries and with the first laws on euthanasia.

Our societies are not yet fully aware of the danger of anti-natal mentalities. In the name of progress and of its superior interests, pressures in favour of a change by an inversion of current cultural sexual trends, familial policies, and fiscal laws are considered to be not politically correct and anti-natal practices continue.

i. The manipulations of human life

Finally, at the turn of the millennium, we have had the privilege of witnessing a wonderful expansion of knowledge about human reproduction, foreseeing possible future applications in the treatment of genetic diseases, which previously had no chance of intervention. As always with science, the applications of marvellous scientific discoveries can be diverted, without strong moral issues, into instruments of oppression against human beings. Knowledge about human reproduction is now faced by a parallel expansion of threatening manipulations of human life.

The elimination of embryos has already taken place, produced in excess in order to increase the probability of outcome of in vitro fertilisation. Genetic knowledge is increasing the number of the conditions by which it is possible to achieve a pre-implant diagnosis, with the consequent genetic selection and elimination of

embryos with genetic alterations. In the case of unwanted twins, a reduction of the number of embryos is proposed. It is possible that in the future so-called twin fission will become a routine, with the aim of obtaining a twin embryo to be used for diagnostic investigation with a bank of homologous tissues.

Summarizing, the doctor, at the beginning of the new millennium appears to run the risk of losing a holistic and personal approach to the patient and having difficulties in managing the flow of information. He is a doctor whose activity more and more depends on technology and he is more and more conditioned in his activity by the decisions of government health and social policies. The relationship with his patient is made more difficult, not only by problems of communication, but also by a latent conflictual confrontation and by a decreased charisma, while the patient seeks more autonomy and the satisfaction of personal desires not strictly linked to the preservation and the recovery of health. A profound revision of educational programs is required to allow him to operate more easily in a society with too many elderly people and very few children, to prepare him to work outside hospitals and to take care of chronic and disabling diseases. Doctors at the beginning of the new millennium appear to be not well equipped to resist the pressure of alternative medicines, cultural pressure in favour of practices against life, and political systems that would like him to be neutral towards the inequalities of our time.

2. The responsibility of Catholic Doctors

If this is the scenario, what can we do as catholic doctors of the third millennium to overcome these challenges, to be prophets, resisting the temptations of money and disengagement, preventing society and our patients from running dangerous risks?

a. The personal level

I think that the first answer is at the level of personal attitudes. We cannot simply live with the culture and the values proposed by the media. We must not seek conflict for its own sake, but we have to be proud of our diversity, convinced that we are the salt of the earth and that our proposal is more joyful and full of life.

Pressed between a utilitarian idea of health, which recognises only some health rights considered socially useful, and health ideologies which propose health practices as a form of cult for a sort of new religion, for which death seems almost to be avoidable and health and fitness are modern Gods, we cannot simply withdraw to the line of a mercantile ideal of medicine where profit (personal and institutional) is the measure of what is right.

Again, we have to place the subject at the very centre of our attention and promote a net of human relationships based on solidarity.

We have to manifest the courage of raising again fundamental questions about life, suffering and death. The pagan vision that is behind the cult of health is afraid of suffering, ageing, death and even birth. To this vision we have to witness the Christian perspective, looking at birth, disease, suffering, care, healing and death as opportunities for growth. The experience of our limits (*finitezza* in Italian) helps us to discover the infinite and the reality about ourselves, breaking the dream of omnipotence and invulnerability.

These should be elementary concepts of our Christian experience, but our way of acting is usually quite distant from the ideal. Even to speak about the possibility of finding spiritual redemption through suffering sounds odd to modern ears, including those of Catholic doctors or of hospital chaplains. A few weeks ago, after the death in Tunisia of an Italian socialist leader who had been sentenced for corruption and had lived for years sick and exiled, I had the grace to listen to his daughter on television, reading a passage of a letter from him to the Pope. In the letter, this man, strong, aggressive, arrogant, intelligent, apparently distant from a Christian lifestyle, wrote that he was offering his suffering to God for the good of Italy and in response to the intentions of the Holy Father.

We have to be convinced that genuine religious experience can help the men and the women of our era to keep spiritual and physical health together and to solve the apparent conflict between the need of personal health and the resources of the health systems, because health *(salus)* and healing are part of the process of salvation *(salus)* and salvation cannot exist if man is not healed in his entirety.

For this reason, presenting to our colleagues and students the sick person as the true image of Jesus *(icona Christi)* cannot be regarded just as the devotional attitude of some simple good spirits, but as the most important contribution, authentically revolutionary, to the process of improvement of the medical profession and health institutions.

b. The responsibility of Associations

A second level of response is that of our Associations of Catholic Doctors.

b.1 Spiritual growth

Our Associations, at a time of pluralism and secularisation, cannot continue to be the clubs of some good persons who from time to time meet to dis-

cuss some interesting ethical problems or join for a beautiful celebration. They have to become a place of spiritual growth where it is possible to receive a Christian inspiration for our professional life, from the living Gospel of Jesus Christ. The Gospel, the Good News of Jesus Christ, can be found alive in the living body of His Church. If our Associations want to continue to be a source of Christian inspiration in a society marked by practical atheism, it is necessary for them to become communities of prayer. They must become, more and more, a strong support for our faith. The members of our Associations of Catholic Doctors must have the possibility to feel a spirit animated by communion and service.

b.2. Communion

Communion is the fundamental of our credibility. Jesus prayed that we might become a single thing, so that the world could believe. Communion is not flatness, it builds up on variety and is in favour of a variety intended as complementarity. A spirit of communion is necessary inside our national associations, between member associations inside FIAMC, and between our associations and local Churches, increasing the links with the bishops and the episcopal conferences.

b.3 Service

Service to the sick person and, more generally, to those in need. Service to the true image of Jesus, to the *icona Christi*, as a visible demonstration of our service to him, manifested by simple but eloquent evangelical signs, like attention and availability to the sick person, diagnostic and therapeutic attention not only for the body, but also for the soul, predilection for the last persons and those in whom society seems not to have interest, the attribution of only relative value to money, and attempt to live social justice.

b.4. The new evangelisation

Communion and service are requisites for us to become effective agents of the new evangelisation. Evangelisation is regarded with suspicion by modern societies and it is out of fashion in the Church itself. The underlying axiom is that we must not impose anything on anybody. However, this kind of approach is misleading. We must not impose, but we have the mission to present our faith. It is surprising, for example, that in European societies, where Islam is the second confession, and sometimes the first in terms of practice, no effort is made to present the Christian Good News. We seem to be indifferent to the faith of our brothers. Again, it is not a problem of imposition, but of being convinced of the beauty of the Christian life, to be proposed, for us in the medical field, for others in other temporal realities, with the simple instruments of communion and service.

c. Social and political witness

The third level is that of social and political witness.

A personal and community attitude, like the one that I have tried to describe, can generate a new culture, which requires entering into contact with other's positions, convinced of our own position, in a dialogue that has to be competitive, because, without attacking others' cultures, it wants to promote our way of living. I think especially of our presence in the universities and the institutional presence of Catholic universities. We are not requested to manifest our Catholicism serving at the altar, but animating the temporal domains of health services with Christian values. There is an enormous activity to accomplish to permeate health systems with the ideals of solidarity and subsidiarity promoted by the Church's social doctrine.

Four examples will be sufficient in this context.

c.1. Catholic hospitals

First, we can work to transform some Catholic hospitals reserved to rich people into hospitals open to everybody. At the same time we have to work for the government recognition and support of non-profit institutions, both Catholic and non-Catholic, serving people in need.

c.2. International Co-operation

Second, we can promote international co-operation, first of all as a contribution to justice and then as an expression of charity, that is of genuine Christian love. It is beautiful that non-Catholic organisations are also working in the field of international co-operation, but it makes me sad that Catholic doctors are unable to express the same level of activity, while religious congregations are abandoning the field. Beyond the good intentions, in fact, some organisations work with a reductive vision of health problems.

c.3 Educational campaigns

Third, we can take part in promotional health campaigns, transforming them into true educational processes. The campaigns for the prevention of drug addiction, of sexually transmitted diseases, and of car accidents, are typical examples of a philosophy of health founded on external protection, without any request for a change of lifestyles. For this reason they are intrinsically amoral. The same campaigns, to become really educational, need people to have a different conduct and to be able to ask for a change.

c.4. Promotion of a life centred culture

Finally, we have an enormous sociopolitical task in promoting legislation in favour of life. Apart from trying to reverse legislation permitting abortion, embryo wasting and euthanasia, or apart from fighting against the introduction of these kinds of laws in other countries, we must feel ourselves engaged in promoting social conditions where life can be accepted and fight against those situations where the dignity and the sanctity of life are humiliated. Next Monday, here in Rome, the fifth anniversary of the great Encyclical "Evangelium Vitae" will be solemnly celebrated. For Catholic Doctors, "Evangelium Vitae" should be continuously seen as

the greatest document of the Magisterium in this field, a sort of "Magna Carta" of our action in favour of human life. Rightly, some people think that the "Evangelium Vitae" should be catalogued as a social encyclical of the Church, rather than as a document with moral teachings.

As a matter of fact, the respect and promotion of life is the basis of every social aggregation which deserves to be considered human. From this point of view, to work in favour of life is, for Catholic Doctors, the most important contribution to human civilisation.

3. The Jubilee

I would like to end this talk with reference to the Jubilee that we are celebrating, the occasion for our meeting here in Rome. Like many brothers of previous centuries, we have come to the tombs of the Apostles Peter and Paul to rediscover the origins of our faith, to follow a path of interior purification, to open ourselves to greater solidarity and fraternity.

Maybe more than medieval pilgrims, men and women living at the turn of the millennium need to begin a trip along the ways going in search of Good and of Truth, trying to understand the deepest meaning of our humanity, something that only Christ can reveal.

The pilgrimage to the tombs of the Apostles then becomes the image of the other pilgrimage, the one lasting our entire life. For this reason, the pilgrimage of the Jubilee can help us to discover again respect for life, the sense of human suffering, the solidarity with those who are closest to Christ on the cross, the meaning of death, which is not a window opened onto nothing, but the true end of human pilgrimage on earth, which will open us to the vision of God's face.

The task of Catholic doctors is to accompany today's men along the most important stations of their earthly pilgrimage, so that it will never become a meaningless walk.

We have examined some of the challenges that touch the core of our Christian witness. As lay members of our Church, we are called to be present in the middle of our profession, trying to change structures and behaviour, so that they can become a clearer image of the healing love of Christ. It is exactly the message of the Jubilee that calls us to a renewal of our life, operating for the growth of the kingdom of God among temporal realities, i.e. in our profession, in study, in scientific research, in teaching.

This will be possible if we renew our faith and have a stronger participation in the life of the Church, otherwise we have nothing special to say to our patients and colleagues.

Prof. GIAN LUIGI GIGLI, MD,
President of FIAMC

The Identity of the Catholic Medical Doctor

Introduction

It often happens in contemporary practice that we encounter motivations behind being a medical doctor which are very different from those that lie behind being a Catholic medical doctor. Both the economic factor and prestige count a great deal. There are examples of medical doctors who earn a great deal of money and who are surrounded by a halo of fame and prestige; and many young people would like to be like them. It is not unusual to encounter medical doctors who have come to the end of their careers after many sacrifices and forms of privation and who declare that they can now take what is theirs. Patients interest such doctors solely in their capacity as clients from whom they can gain the greatest possible advantage. They are only interesting because of their wallets, rather than being seen as people who are in need of medical help and care.

However, not all medical doctors are like that. There are medical doctors who greatly honour the medical profession and who constitute a valuable example – in terms of generosity and expertise – to be followed. And more than one of these physicians have asked themselves about their own identities, not only as Catholics but also as Catholic medical doctors. The following paper seeks to be merely a first attempt to provide answers to this question of identity.

It must be recognised that this paper is written in a language that is incomprehensible to those who do not have faith. For the physician who does not have faith in Christ and his Church, everything that is stated here does not have sense or meaning. It is something which is absurd and which seems to be directed towards people who are mad or foolish.

This is the same for faith in general. St. Paul said that the account of the Messiah who was crucified and rose again was offensive to the Jews and seemed madness for non-Jews. However, this is very much wiser than the whole of human wisdom, and what can seem a weakness in God is in reality stronger than the whole of human power (I Cor 1:23-25).

Basing myself on the meaning of the identity of the Christian as something which follows from his baptism, I would like to dwell solely upon the identity of the Catholic medical doctor as a medical doctor.

I will take as my starting point the "Charter for Health Care Workers" published by the Pontifical Council for Pastoral Assistance to Health Care Workers, which in turn refers to

the thought of the Holy Father John Paul II on the question and to the identity of the physician as outlined by the Pope. With reference to that identity I will seek to outline certain ideas about how it should be interpreted and commented upon.

The Charter of the Health Care Workers

The Charter for Health Care Workers lays down the following in relation to the Catholic medical doctor. His profession calls him to be a guardian and servant of human life. This must be done through a vigilant and caring presence at the side of the sick. Health care activity is based on an interpersonal relationship. It is a meeting between trust and conscience. The trust of one who is ill and suffering and who entrusts himself to another man who can help him in his need and who comes to his assistance to care for him and cure him.

The sick person is not only a clinical case but a sick man towards whom the medical doctor must adopt an attitude of sincere sympathy, suffering with him through a personal participation in the concrete situations of each individual sick person. Infirmity and suffering are phenomena which, analysed in depth, go way beyond medicine and touch upon the essence of the human condition in this world.

The medical doctor who takes care of these situations must be aware that it is precisely here that the whole of his humanity must be involved, and absolute dedication is required of him. This is the mission which characterises him and it is the fruit of a call or vocation that the medical doctor listens to, personified in the suffering and imploring face of the sick person who in entrusted to his care. Here there is the connection with the mission of the medical doctor to give life and to give it in abundance (Jn 10:10). This life transcends physical life to the point of reaching the heights of the Most Holy Trinity; it is the new and eternal life which consists in communion with the Father, towards whom each and every man is called freely in the Son, by work of the Holy Spirit.

The medical doctor is like the Good Samaritan who goes to the side of the sick man and makes himself his neighbour through understanding and sympathy, in a word through his charity. In this way the medical doctor takes part in the love of God as an instrument of its diffusion, and in this way is infused with the love of God for man.

This is the healing charity of Christ, who passed by doing good and healing (Acts 10:38). And at the same time it is charity towards Christ who is present in every sick person. He is the person who is cared for in every man and woman, "I was sick and you visited me", as the Lord will say in the Final Judgement (Mt 25:31-40).

It is thus more than evident that the identity of the medical doctor is the identity received from his therapeutic mission, from his ministry of life. He is a collaborator of God in the recovery of the health of the body of the infirm person. The Church sees the work of the medical doctor as a moment of his ministry, and sees service to the infirm as an integral part of her mission.

The Church well knows that physical malady imprisons the spirit, in the same way as malady of the spirit has a negative impact on the body. In this way, the medical doctor, through his therapeutic ministry, takes part in the pastoral and evangelising action of the Church. The paths he has to tread are those indicated by the dignity of the human person, and thus moral law. And this is especially the case when he has to carry out his activity in the field of biogenetics and biotechnology – bioethics furnishes approaches and sets out his principles for action.[1]

The Identity of the Medical Doctor

In this position of the Pontifical Council for Pastoral Assistance to Health Care Workers, which is, as is clear from the references, also the position of John Paul II, is to be found a summary of the Christian identity of the medical doctor. As I have already pointed out, I will seek to reflect upon this identity and specify in particular that this is an identity received from a vocation and a mission which is at the roots of a ministry which is very special: the ministry of life, the ministry of health.

Vocation and the Church

Let us begin by referring to the meaning of vocation within the Church. It is very often the case that etymologies help us to go back to the original meaning of words that we use frequently but which seem to be worn out by use. One of these is the word "*Chiesa*" ("Church"). Let us examine the two etymologies of this word – the Greek and the Latin. The Greek etymology leads us to the verb "*ekkalein*" ("*chiamare*" or "to call"). "*Chiesa*" ("Church") is the plural participle of the verb "*ekkalein*" and means "the called".

Thus, placing ourselves within the Latin etymological perspective, the Church is the effect of "vocation". "Vocation", speaking in etymological terms, is the Latin substantive of the Latin verb "*vocare*" – to call (the same as "*ekkalein*"). It means, therefore, the same call that unites the called, that is to say which gathers together the Church. Vocation, therefore, makes the Church.

The only "vocation" or fundamental call is that which God makes through the Word, by which He calls to life everything that exists, and this call, this primicerius "vocation" is Christ, who is the Word of God through which everything that exists and each one of us is called to life (cf. Eph. 1:3-10; Col. 1:15-20). In particular, it is interesting to note that the highest form of call today made by God in relation to everything that exists, the highest presence of Christ in the world, achieves realisation in the Eucharist, which is a memorial, making Christ present in the today of history (cf. Lk 22:19).

In this call of God we discover three essential moments which constitute it and which we can summerise with the four following words: "to be",

"with", and "for". This is because we are called *to be (to exist), with God, for others.* This, for example, we can observe in the call that Christ makes to his disciples (Mk 3:14-15), and above all in the call that he makes to the Virgin Mary asking her to become the Mother of God the Messiah (Lk 1:26-38). This, however, is a paradigm which covers the whole of the history of Salvation.

These three words of vocation will help us as a model which we can employ to reflect on the doctrine of the Pope in relation to the identity of the Catholic medical doctor, something which we set out in the "Charter for Health Care Workers".

1. "To Be"

When we speak about "being" in vocation we speak about total existence. God speaks and everything begins to exist. As Genesis declares: "And God said: let there be light. And there was light" (Gen 1:3). When God utters His Word this becomes practice – it does what He says and everything achieves its consistency, its beginning, an end, its totality.

When we speak about the authentic Catholic medical doctor, he is such because of an authentic vocation received from God Himself, from whom he receives his whole existence, although naturally enough without excluding the collaboration with the call which is implemented by the medical doctor himself.

What is the medical vocation to which he is called by God? Let us now outline certain of the features of the "to be" of this call.

1.1. Profession

First of all, let us state that God calls the medical doctor to a profession which is not the same as being called to disengage from another office. In history three professions are principally recognised: that of the priest, that of the physician, and that of the governor or judge. It should be said that a profession is linked to the profession of faith; it is something with a religious character. A profession is not something of a strictly juridical nature because what is juridical in a positive sense can be fulfilled or not, or something which can change according to the wish of those who contract an obligation – a profession is an obligation and a responsibility which is contracted with God Himself. It is a responsibility, and responsibility means, in essential terms, the ability to respond. The word "respond" comes from the Greek "*spenden*", which originally meant "a sacrifice of libation to God". Professional responsibility at a medical level means a "*compromesso*" ("an agreement") (from the Greek word "*syngrafein*" which

means "to write together") which is written as a dual encounter between man and God.

From this sacredness of the medical profession there sprang the Hippocratic oath – the oath not to do harm to the patient, to act always for his best interests, and to be totally in favour of life at all of its various stages. This is not an oath which is made to a patient but is something which is addressed directly to God. The vocation of the medical doctor in this context is a vocation that is born from the love of God, and it is God whom the medical doctor follows in this profession, as the highest loved Good.[2]

1.2. The Love of God in the Physician

However, despite the sublime character of this Hippocratic position, it is limited and defective. I referred to the love of God, but this love, according to the classic Greek mentality, the mentality of Plato and Socrates, to which Hippocrates belonged, is defective because it assumes need and is never fullness. Indeed, for classical Greek philosophy God does not love. He is infinitely lovable, but He does not love, because to love means lack and God cannot be defective in any way. Love is only specific to man who is in need and who wants to obtain satisfaction; it is not something which belongs to God, who is All-perfect. In Greek mythology, love is born with Poros and Penia, in the marriage of Aphrodite. Poros represents the expedient, need, and Penia represents poverty. Uniting need with poverty, love is born as self-interested desire.

This mentality is completely corrected by divine Revelation: God himself is Love. This is the deepest definition of God. His love is not lack of something but the highest diffusion of His own goodness, which meant that God the Father so loved this world – which he created out of a diffusive love in itself – as to give his Only Begotten Son to it to the point of death (Jn 3:16).

For this reason, the Christian medical profession centres around love. But this is not a self-interested and impoverished love, a Hippocratic love. It is rather a love which imitates the perfect love of God and has its paradigm in the Good Samaritan who in this way suffers together with the sick person, feels sorry for him, and supplies everything that is needed for him to regain his health. In this way the Good Samaritan is the example to imitate for the Christian medical doctor. The Good Samaritan is the figure of Christ who had compassion for the whole of sick and fallen humanity, and who raised it up to its deification. He is infinite love and he is both in he who loves and in he who is loved – he is in both kinds of individuals and with fullness. In this way the Good Samaritan is the figure who determines the identity of the medical doctor, who has such compassion for the patient that he does everything he can to heal him, out of love for fullness.[3]

When speaking about the

love that the medical doctor must have towards God, and thus towards his patients, the Holy Father Pius XII spoke to us about the commandments of the law of God and their bearing upon medicine. He spoke about the first commandment, which exhorts us to love God above all things, and of the second commandment which tells us to love our neighbour as ourselves. The idea is that the identity of the medical doctor is to be found in this love when his relations with his patient are permeated by humanity, by comprehension, by sensitivity and by care and concern.

Pope Pius XII completed this picture of the physician by referring to two other commandments, and above all to the fifth commandment: "do not kill", and to the eighth: "do not bear false witness".[4]

1.3. Respect for Life and the Defence of Life

The fifth commandment reminds us that the identity of the Christian medical doctor lies in the fact that because of the love that he is obliged to have towards God and his patient, the physician is totally obliged to defend life at every stage but above all else at its weakest stages, such as those which are to be found at the beginning and the end of life. His personality is marked out by a clear and absolute "no" to abortion and euthanasia. The fifth commandment covers the whole of the meaning of human life which is seen as a gift given by God in sole stewardship to man and woman, and which should have its origins only within marriage.

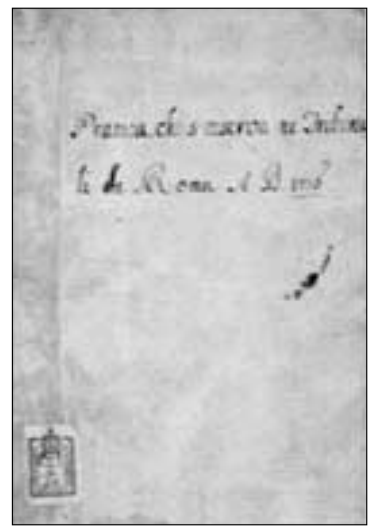
1.4. Medical Training

His Holiness Pius XII observed of the fifth commandment, "do not bear false witness", that the physician has a clear duty towards truth, both the truth of illness and health and the truth of medical science.[5]

The identity of the medical doctor comes from the training that he receives, but if we look at what he receives in many faculties of medicine we can see that this is a very weak kind of training. Indeed, the curriculum of the medical career is based upon two essential parts. The first is basic knowledge and the second involves knowledge obtained through the clinical sciences which are divided up into disciplines, or from analysis of the various organs of the human body.

It is obvious that this teaching must be imparted, but what is often encountered is a biotechnical reduction. In the presentation of various subjects the anthropocentric values are lost, as indeed are the ethical, affective and existential values. The medical doctor becomes defined by the needs of the patient and by the requirements of an economistic health-care system which is completely indifferent towards the violation of human rights, and especially of human life.

It often happens that we encounter in the present-day clinical applications the paradigm of fragmentation and reduction of the patient to organs or biological and technological functions and medicines and drugs. There is an attempt to reach dominion by fragmented specialised knowledge without a vision of the overall picture through knowledge and expertise connected with other human fields beyond that of medicine. The idea of health is that of passive adaptation to pathogenic stimuli of a biophysical nature. Clinical adaptation very often takes place with exclusive reference to the requirements (including those of an economic character) of the national health-care system. One can observe a loss of ethical values in medicine and the anonymity of patients. One can also observe that little value is bestowed on the existential aspects of the medical profession, on the figure of the patient, of the medical doctor, and of the nurse.



In response to all these questions and issues connected with "being" a medical doctor from the beginning of the professional training that he receives, a series of methods have been formulated which have been conceived in order to make teaching active, especially through so-called PBL (Problem Basic Learning) and the method of teaching directed towards the community. This last sees the medical person as a person who has to be skilled and competent at the relational and scientific levels, is integrated into a communitarian reality, is able to co-operate with other health-care figures and administer the resources which are available in a process of continual training, is always an advocate of the health of the patient, and is able to link theoretical knowledge with medical practice, thereby engaging in constant training.

This kind of medical training would provide a new understanding of health and illness, and would engage in the prevention and treatment of illness within the context of the individuality of the patient which is completed in his family and in the whole of society. It would thus develop a stage of initial learning based more upon curiosity and constant investigation than upon passive acquisition. It would reduce the weight of information and would favour direct contact with patients through a personalised analysis of their problems and the whole of their curriculum.

One should, therefore, draw up a programme based upon the following set of principles: 1. the existence of a comprehensive and final meaning of medical knowledge; 2. the definition of its epistemological orientation; 3. the definition of the values, motivations, psychological maturity, and quality of the objective knowledge and relational methodological capacities to be applied to the practice

of the profession; 4. the definition of the values, motivations, capacities and quality of the training of teachers; 5. the definition of the general and specific objectives of training; 6. the definition of the didactic methods. These principles accept the epistemological knowledge of present-day medicine which sees health as a psycho-biological construction brought about by the accessibility and quality of the resources of the person, and which is directed towards providing an overall response to the fundamental questions of human existence.[6]

1.5. Permanent Training

The identity of the medical doctor is not modelled once and for all by his initial training. It must be extended through permanent training. It requires a very careful instruction of medical students, but at the same time a continuous and progressive training of the teachers who teach medical teaching courses, a training which at times is lacking. It is above all the teachers who are responsible for the promotion of new medical doctors, which is something which they must never facilitate if they in all conscience see that a student does not have the capacity to carry out such a sensitive mission.

In virtue of the eighth commendment all medical doctors must respect professional secrecy, and as has already been observed in this paper they must have a well-founded medical learning and culture which must constantly improve through permanent training.[7]

2. "With"

We have observed that the second feature of the Christian vocation is expressed through a readiness to engage "with": with God. This means that the whole of that vocation exists to be with God our Lord who is He who makes man able to carry out his mission, which without God's strength it would be pointless to pursue. We can read in the Book of Exodus what Moses says to God on Mount Horeb: "who am I to present myself before the Pharoh of Egypt and free the Israelites from Egypt, and God answered: I will be with you" (Ex. 3:12).

2.1. The Transmitting of Christ the Physician

In this contrast we can delineate the deepest values which must characterise and shape the identity of the Catholic medical doctor. The personality of the Christian physician is to be identified in this way as the transmitting of Christ the medical doctor. Christ invited his apostles to take care of every form of suffering and illness, and said to them: "I will be with you until the end of the world" (Mk 16:17; Mt 18:20). The medical doctor thus engages in the healing ministry at the side of the apostles as a continuation of the mission of Christ and as his transmittance. We have to understand this transmittance in all its breadth. The medical doctor must express the whole of the life of Christ because this is the presence of Christ within the medical doctor. This is because Christ cares for every infirmity and illness through all of his actions understood in overall terms. The miracles of healing which he worked, including the raising of the dead, were not definitive in his struggle against the evil that is within humanity, against its suffering and death, but only a sign of the profound reality which is contained in his death and his resurrection.

2.2. Pain

Jesus took upon himself all forms of suffering, all forms of pain, all forms of infirmities without any kind of exception, and included them in his own death as the death of God made man, and this so that nothing connected with pain was excluded. And from his death he undid death itself, he conquered it with the fullness of his resurrection. One of the great questions of the medical doctor has always been the problem of pain, but this question finds its answer here alone, when pain does not appear as something which is negative but as a positivity which culminates certainly in death but in a fertile death of resurrection as well.

In the same way the physician must care for and treat in a way which transmits the death and resurrection of Christ. To obtain this transmittance there needs to be an identification of the medical doctor as such, as a healer, with the healing Christ. This identification, today, takes place in particular in the Eucharist and in the other sacraments. The sacraments are the historical presence of Christ in today's time, in the concrete moment which we traverse in life.

2.3. Health

As a result, the medical doctor must realise that health is an overall phenomenon and he must not speak about physical health as being something radical different from overall health – something we call eternal health, or to put it in more suitable terms, salvation. For this reason, the ministry of the medical doctor is an ecclesial ministry which is directed towards the salvation itself of man from his body, but which also includes other aspects. It is for this reason that we have described health as a *dynamic tension towards physical, mental, social and spiritual harmony, and not only the absence of illness, which gives man the ability to fulfil the mission which God has entrusted to him, according to the stage of life in which he finds himself.*

The mission of the physical doctor, therefore, is to work so that this dynamic tendency towards overall health is achieved, as indeed is required at every stage of the life of this concrete man his patient, so that he can carry out the mission which God has entrusted to him.

Hence it is incongrous to reduce the medical function merely to the physical-chemical dimension of illness. Its function is of an overall character and in addition must not be static. It must form a part of the dynamism of the patient which works towards his own harmony.

In this context, death does not appear as a frustration for the physician but as his tri-

umph. This is because he has followed the patient in such a way that his patient has been able to express his talents at each stage of his life. When the patient arrives at the end of his life the medical function of the physician ceases, not with a cry of impotence but in the satisfaction of the knowledge that a mission has been carried to its fulfilment, both by the patient and by the medical doctor himself.

In this way the physician is really with Christ and his profession is identified with this communion with Christ himself, and thus the medical doctor unites with God the Father in the same way as a son comes to his father, and his professional love becomes converted into the action of the Love of God, which is the Holy Spirit. For this reason, the Christian medical doctor is the person who is always guided by the Holy Spirit. From the Holy Spirit and with the Holy Spirit one grasps all the empathy which must exist between the medical doctor and his patient, all the due humanisation of medicine and all the need for realisation and permanent training, because the Love of the Holy Spirit makes the medical doctor a person who is above all open to others. This is what he has committed himself to do before God with his profession of Faith which means his medical profession. In this way we come to delineate the third dimension of the medical identity – to be for others. This is the "for" of his vocation and his professional identity.

3. "For"

When God chose Moses it is very clear that he did this in order to ensure that his people escaped from the power of the Egyptians. God said: "I have come to save you from the power of the Egyptians" (Ex. 3:8).

The medical doctor cannot become shut up within himself. He cannot merely think that he now has enough money, that he no longer needs to work, and that for this reason he can retire from his profession. A real physician is a physician for the whole of his life and if he has really received this vocation he will always maintain it, and he must practice it for the benefit of humanity as a mission received for the good of everybody, and in relation to which he must render account to God when God says to him: "I was sick and you visited me"(Mt 25:36-43).

3.1. Openness to the Patient

We have observed that the love of the medical profession follows the love of God which is in itself diffusive. The medical doctor cannot imprison his knowledge in pure theories and laboratories. He must spread it for the benefit of the community. He has received the gift of caring for life and enabling it to grow. His vocation is for life, and never for death. To be for death would be to extinguish the mission which God has entrusted to him for each person. Pope John Paul II declares that to the religious ministry is joined today the healing mission of medical doctors in upholding human life and all those special contingencies in which life itself can be compromised by an intention of human will.

In their deepest identity medical doctors carry with them the fact of being ministers of life and never instruments of death. This is the innermost nature of their noble profession. They are called to humanise medicine and the places in which they practice their profession, and to ensure that the most advanced forms of technology are used for life and not for death; and in this they should always have as their highest model Christ himself, the physician of souls and bodies.[8]

Pope Pius XII declared that the Catholic medical doctor must place his knowledge, his powers, his heart and his devotion at the service of sick people. He must understand that he and his patients encounter each other placed beneath the will of God. Medicine is a reflection of the goodness of God. The physician must help to ensure that the sick person accepts his illness, and he himself must protect himself against being dazzled by technology and make sure that the gifts given to him by God bear fruit. He must not yield to the pressures to make him engage in attacks upon life. He must be strong when faced with the temptations of materialism.[9]

The good medical doctor must in this way possess the dianoetic and political virtues and ensure that they really are virtues, that is to say by adopting an approach whereby both the virtues of the theoretical sciences and the virtues of actual practice can meet in him as though they were his second nature.[10]

3.2. The Fundamental Qualities of the Medical Doctor

Thus we come to categorising and characteristing the fundamental qualities of the medical doctor under five headings: awareness of responsibilities; humility; respect; love; and truthfulness. Awareness of responsibility leads him to work with the sick man and to be aware that a medical doctor is the person who points out the paths to be followed. Humility tells him that the medical doctor protects his patients and not the contrary; humility leads him to see himself as the relative of the sick person. The medical doctor cannot speak about "his" patients – the patients must speak about "their" doctor. The physician must receive his patients in a way which follows what is written in the architrave of an old German hospital: "*recipere quasi Christum*", that is to say as though they were Christ himself. Respect and love in relation to the sick person, something which has already been discussed in this paper, are the bases of his humility. He knows that he is the steward of a mission for which he does not possess the necessary strength but he also knows that he receives such strength from those who direct him towards that mission. Truthfulness contains in itself being aware of the great trust which is given to him by the sick person in revealing his innermost problems and difficulties. Truth is required in both diagnosis and treatment not only at a physical level but in an overall sense, that is to say from a mental, social, psychic and spiritual point of view. He must

never carry out experiments on the sick person if he sees that the danger is not proportionate to the benefits which he is seeking to obtain. Such a policy must be absolutely necessary and the patient must give his consent. The medical doctor must inform the sick person about the evolution and development of his illness, tell him the truth about his condition, and all this at the appropriate moment and in the ways that are the most suitable. He must link his action with the action of the priest because both missions – the mission of the priest and the mission of the physician – are intimately bound up.[11]

3.3. Portrait of the Medical Doctor

The "Portrait of a Physician" from sixteenth-century Spain is certainly of great contemporary relevance. This portrait employed a flowery language to

describe Enrique Jorge Enriquez, and the words which were used were the following: "the physician must have fear of God and be very humble, not proud or vainglorious, he must charitable with the poor, meek, benevolent, friendly and not vengeful. He must not reveal secrets, he must not talk too much, he must not be a gossip, he must not flatter, and he must not be envious. He must be prudent, moderate, not overly bold ...he must be restrained and practice honesty and listen with great attention; he must work for his art and hate sloth. The physician must be very well read and know how to accept that others are right".[12]

At the present time we refer to medical excellence, that is to say to what Aristotle called "*teleios iatròs*" (the perfect physician) and to what Galenos termed "*aristòs iatròs*" (the best physician).

3.4. Morality and Law

In this paper it has been observed by way of a principle that the medical profession is something which rises above law and is to be found in the dimensions of morality. This is certainly true, but we cannot depart from medical law. Medical law without a suitable morality would be mere arbitrariness based upon unconfessable interests. Morality without medical law would be something confined to general principles and without direct application. The rules and regulations of medical law must be sufficienctly clear and brief to facilitate the action of the medical doctor. The guiding principle is always the same: the purpose of the medical doctor is to help and to heal, never to do harm, and never to kill.

Special reference should also be made to the field of ethics, the field of morality, in which the medical doctor must be competent, even though it very often happens that he is not a specialist. For this reason we need bioethical committees in every health-care centre and their creation in teaching institutions to achieve an open dialogue with specialists who belong to the various relevant disciplines.

In this way the medical doctor becomes aware that he can bear witness to God in all medical, trade union, political etc. contexts, and can be a valid instrument of ecumenical dialogue with other religions, in particular because illness does not recognise religious boundaries. In this way the medical doctor will actively belong to the Church both as an individual and as the member of a group.[13]

3.5. Team Work

In order to the carry out this very demanding mission, the medical doctor must not remain shut up in his own individuality but must open himself first and foremost to other medical doctors and have sufficient humility to work with other people and in a team, both with regard to strictly structural questions and in those relational areas that bear upon fields where he is not necessarily in charge because in a certain sense they are beyond his competence – for example where sociological, anthropological and political issues are at stake, or in technical fields which are outside his profession, i.e. everything connected with the field of computers and informatics.

Thus within this openness in the Spanish medical field there emerges what two authors call the decalogue of the new medical doctor, which they outline in the following way:

1. Work in a multidisciplinary team and with a sole ultimate director. 2. The more scientific the professional person, the better. 3. The human aspects of professional practice should become more emphasised. 4. Action should be adapted to scientifically allowed diagnostic and therepeutic protocols. 5. Medical doctors should be aware of expenditure. In addition to the protocols the guidelines of good practice should be followed. 6. The medical doctor should facilitate working together, and solidarity, with work colleagues and patients. 7. The medical doctor should believe that all action of care can involve preventive action and thus the promotion of health. 8. The medical doctor should constantly bear in mind that he must take care of the need to obtain satisfaction for the user of the service. 9. The special patient attention units should become stronger, and should give increased space to the complaints and suggestions produced by patients. 10. It is of fundamental importance to apply ethical principles to professional activity[14].

Conclusion:

Being a Catholic medical doctor is a ministry which springs from a vocation within the Church. It is the mission of healing. It is strongly linked to God our Father and expresses Christ the physician, full of

Love, which is the Holy Spirit. To be a medical doctor is a path by which to reach and achieve the fullness of the human being. It involves a special nearness to, and intimacy with, God; and it also means an openness and a total giving to other people. This, then, is the Catholic identity of the medical doctor – to be the transmittance of the healing Christ.

H.E. Mons. JAVIER LOZANO BARRAGÁN,
Archbishop-Bishop Emeritus of Zacatecas, President of the Pontifical Council for Health Pastoral Care

Notes

[1] The Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* (Vatican City, 1995), 1-7.

[2] Cf. DIEGO GRACIA, 'Il Giuramento d'Ippocrate nello Sviluppo della Medicina', *Dolentium Hominum* (31), 1996, pp. 12-14.

[3] Cf. V. CAPPELLETTI, 'Dove c'è Amore per l'Arte Medica, c'è Amore per l'Uomo', *Dolentium Hominum* (31) 1996, pp. 22-28.

[4] Cf. PIUS XII, 'Discorsi ai Medici' in *Orizzonte Medico* (Rome, 1959), pp. 46-54.

[5] Cf. PIUS XII, 'Discorsi ai Medici', pp. 46-54.

[6] G.R.BRERA, 'La Formazione dei Medici del Terzo Millennio. La Scuola Medica come Scuola di Uomini and Umanità' (Conferenza Inaugurale dell'Anno Accademico 1998-1999. Università Ambrosiana di Milano, inaugurazione della Scola di Medicina).

[7] Cf. PIUS XII, 'Discorsi ai Medici', *loc. cit.*

[8] Cf. JOHN PAUL to the XV Congress of Catholic Doctors (AMCI), 'Cinquant'Anni di Vita per la Vita', *Orizzonti Medici* (1994), pp. 105-114.

[9] Cf. PIUS XII, 'Radio Messaggio al VII Congresso Internazionale dei Medici Cattolici (11.9.1956)', 'Discorsi ai Medici', p. 503.

[10] Cf. D. GRACIA, 'Il Giuramento d'Ippocrate', pp. 12-14.

[11] Cf. P.MAZZINI, 'Arzt un Seelsorge', in LTK(1).

[12] Quoted by DIEGO GRACIA, 'Il Giuramento d'Ippocrate', p. 26.

[13] Cf. S.LEONE, *Orizzonte Medico* (6) Nov-Dec. 1996, pp. 10-11.

[14] M. ANSENJO and A.ANGEL-TRILLA, 'Necesidad de Nuevos Profesionales para las Nuevas Situaciones Sanitarias', *Todo Hospital* (149) Sept. 1988, pp. 497-499.

The Identity of the Catholic Nurse

Catholic nurses love to state that they have their own identity. For this reason, they often find themselves in opposition to their environment, which does not appreciate the fact that they want to address themselves to their professional task with specific concerns and priorities. According to the most indulgent, this means adopting a mentality which belongs to other times. But often it is the very legitimacy of their aspirations which is called into question. Some people dispute the right of these nurses to have an originality as Catholics because, they say, the requirements and needs of their professional service must determine the behaviour of each and every person, irrespective of sex, race or faith. Others, for their part, perceive in the upholding of a specific identity an approach which is contrary to the development of the modern world which asks us to end our differences and to unite to construct a new society. The questioning to which Catholic nursing personnel are subjected must be examined with lucidity and courage. It is possible that certain ways of thinking and expressing ourselves must change, but, in basic terms, we cannot stop affirming that the fact of being Catholics affects the behaviour which we adopt within society and in our professional activity. The fact that this specific character is denied, forces us to reflect not only on the reasons which lead us to say that we are Catholics but in addition, and above all else, on the consequences that the upholding of a specific identity can have for our professional activity.

Some present-day societies no longer make Christianity the basis of their public organisation; others are outside this vision of existence. All dispute the right of Christians to behave in a way which is different from most of those people who make up those societies. Whether these are societies born from Western civilisation or from other civilisations, Catholics feel in sociological terms that they are in a minority, and even that they are treated as foreigners in their own country. They, however, realise that from the human and religious point of view they are in a majority. Their difficulty comes from the fact that the religiosity of popular movements has still not yet found the instruments by which to express itself at a socio-economic level because the populations concerned have still not grasped the strength that they represent and have not yet found ways by which to achieve forms of co-operation amongst the religions. This is the approach with which I would like to set out the identity of Catholic nursing personnel and to insist upon the responsibility of the CICIAMS, which can indeed be representative of the religious aspirations of humanity.

My paper is divided into three parts: 1. the challenge of identity; 2. the legitimacy of the upholding of a specific Catholic character within society; and 3. the consequences which flow from this for Catholic health care professionals. This last point is the most sensitive because these professionals must keep intact the inheritance received from the past and at the same time adapt themselves to the new prospects experienced by contemporary society.

1. The Challenge

The answer of believers to the opposition that they come up against within society must be adapted to the specific challenges of their epoch, which today concerns the crisis of values within Western society and the new kinds of relations which are established between religions. We will not here analyse these causes at a deep level but only recall the challenges which Catholic nursing personnel must address themselves to because of the plural-

ism of Western societies, the crisis of values which is present within non-Western societies, and the prospects created by the drawing near of the various spiritual and religious families.

a. The Calling into Question which is Caused by the Pluralism of Western Civil Society

There is a tension within societies which are based upon the Western model between Catholics attached to certain values and the holders of a militant/narrow secular approach who exercise a determining influence on public opinion through the mass media, which, indeed, are under their control. Western societies are no longer based upon the values of Christianity. Even though some of them may continue to refer to Christianity in their constitutional documents, they all live under what is called the regime of pluralism. In this system the state is no longer the guarantor of an interpretation of life, and even less of a religion, but an arbiter between the different currents of thought which are expressed. As Cardinal Pavan observes, just as the state is not competent to define what is beautiful so also it is not competent to say which religious truths should be believed in.[1]

The advent of pluralism affects the way in which Catholic health care personnel live out their identity. When the CICIAMS was established it was possible to limit reflection about Catholic identity to questions concerning professional competence and good approaches towards the sick or towards colleagues because this was a time when society was prepared to see in Christianity the founding vision of its unity. The adherence of the populations to the ideals that Christianity proposed justified the hierarchy of values that legislation established in such societies. This type of stable society was led to insist upon the contents of the activity of the nursing staff in relation to professional competence, taking care of sick people, concern with families, and relationships within hospital service. Today this is no longer the case. New responsibilities have been added to the activity of nursing staff. Societies which for centuries lived under the exclusive, or almost exclusive, influence of Christianity have had to open themselves up to pluralism. This means that those who govern are obliged to concede rights which are the same for everybody whatever their creed may be. From the moment when collective feelings were no longer centred around transcendent spiritual values whose general acceptance ensured the unity of society, this unity had to be searched for in other paths: that of the 'politically correct', which imposes a way of thinking and marginalises those who reject it; or that of dialogue with a view to defining the contents of the common good *hic et nunc*. Catholic nurses support this last path because it allows the construction of the unity of societies based upon respect for the opinions of everybody. This approach is that which was adopted by Vatican Council II and recent Popes. Paul VI and John Paul II spoke and have spoken about the need to construct a 'civilisation of love' which should be counterposed to that civilisation of a practical and inhuman materialism which now seems to prevail. In this way the upholding of a Catholic specific nature is a consequence of our social anthropology. This last, in praising responsible freedom, cannot accept that imposition of norms which is attempted by certain forces which exert pressure.

b. The Crisis of Values in Non-Western Societies

A large number of societies do not accept the idea of the person, or, being within the Muslim line of development, dispute its role as an innovator which is given to it in the West. The Asian countries, for example, which are based upon Confucianism, Hinduism or Buddhism, base their unity upon values which do not have connections with Christian culture. From this it results that Christians too often appear as foreigners in their national communities. A similar situation exists in Islamic countries where the Koran is seen as the sole source of inspiration for social behaviour, when, that is, it is not seen as the fundamental law of the state.[2]

The predominant values in Asian societies are those which place man in a social group and make him a servant of the collective entity. Indeed, the notion of the person and that of his supernatural destiny are for these societies incomprehensible. Islam certainly has the notion of the person but locates the responsibility of man not in the initiatives which write the design of God into reality but in the observance of the rules contained in the Koran. The fact that Christianity is open to pluralism (which also raises problems of adaptation in the West) introduces a new element into its civilisations. For centuries the Christian presence was seen as a foreign aggression. Today it widens the possibilities for a concertation between spiritual forces at a moment when globalisation is imposing a reassessment of the traditions and ways of thinking which have been received from the past. This is not a question of abandoning ancient traditions as though they were old clothes but of enriching them by opening them up to new aspects of the human experience.[3]

In this way Western Christians and those who belong to other cultural traditions find themselves faced with the same problem. The challenges which they have to address themselves to is fundamentally of the same character. This is

the angle from which the identity of Catholic nursing staff must be considered in a world in which the various cultures are based upon values different to their own.

c. The Crisis Caused by the Diversity of the Spiritual and Religious Families

The analysis which has just been undertaken has often led to people speaking about Christians who have become or who were minorities in their own societies. This view can be justified from a quantitative point of view because they are not or are no longer always the majority and can have the impression that that they are dominated and even discriminated against. However, this is not precisely true. One of the characteristics of modernity is the freeing of spiritual forces. These are no longer to be identified with a political regime, bestow less importance on their sociological dimension, and in this way acquire a more vital awareness of their specific mission within society, that of being the advocates of a vision of existence which is open to higher values, and for Christians such as ourselves this means divine transcendence.

Every religious tradition draws its meaning of the human future from the consequences of the moral behaviour of its members within society. All such traditions have in common the fact that they do not close man up in a space which is only political or economic. They all have the vocation to develop this spiritual dimension which is present in each and every man. This shared concern explains why relationships of neighbourliness and dialogue are formed, most often at the roots, that is to say in professional teams, between spiritual men of different religious traditions.[4] The meaning of life, the meaning of a moral responsibility which leads to a recognition of each and every man, draws people together, whatever their religion may be. There exists, beginning with Vatican Council II, an ecumenical dimension to action which by now should be included by Catholic health care workers in their conduct and behaviour: they are not the only people to be concerned with the lives or the health of sick people. The associations which have generated these concerns, and make of these concerns the centre of their activity, attract non-Catholics who, indeed, ask to belong to them. The Catholic nurse and the associations to which he or she belongs must be the basis of a counter-culture. If culture can be defined as an integrated and hierarchical bloc of values around which the members of a society move, if this synthesis excludes others and imposes what is 'politically correct' or only one line of thinking within the geographical area where it dominates, the counterculture will be that which tries to achieve a new integration of values around those of the person.

This is the challenge which now faces Catholic health care personnel. How can we meet it? Correct thought within the nursing world often imposes living in a contradiction. On the one hand, the approach is universalist and generous but on the other there is silence in relation to the economic logic which regulates the profession and ensures that the rich are people who reserve to themselves the possibilities of having the most advanced and sophisticated forms of care and treatment. On the other hand, the sick person is treated and looked after but a culture of death is fostered and encouraged.

2. The Legitimacy of the Upholding of a Catholic Identity

The dangers of an approach of indifference caused by the fact that doctrinal statements have fuzzy associated configurations is often condemned. A real uncertainty exists in relation to the word 'truth'. Classical philosophy, Thomist and Aristotelian philosophy, perceives in truth the fact that a thesis conforms to beauty, good, truth, and justice. All the judgements refer the particular cases which they have to examine to these transcendental ideas. Truth is not subjective, what each person perceives is a partial understanding of an objective truth. Existence is a fact whose meaning all cultures inquire into and ask themselves about.

The Catholic has an interpretation of existence which distinguishes him from everybody else. He does not call it an intellectual theory or a philosophical doctrine or a religion which he has constructed in his wisdom in order to understand what is incomprehensible. The Christian is a person who follows Christ. He sees in Christ a model, and he imitates him, rather than copying in today's life the approaches of two thousand years ago. He conforms himself to Christ, he drinks in his feelings and sentiments. He walks along the path which Christ walked along (1 Jn 2:6). As St. Paul said, bear within you the feelings of Jesus Christ. He bases himself, therefore, on Christ's method in order to make others discover what the professional relationships lived out by the believer can be.

I remember a visit that we made during the African seminar held last December in the basilica of Yamousoukro in the Ivory Coast, where there was a statue of the Virgin which had been sculptured out of wood by a prisoner. This man, we were told, had been a Muslim. However, he had managed to so fill himself with the feeling of Mary that he could carry out this work to its conclusion, which in the end led him to the faith and to conversion. The process undergone by this artist clarifies to us the way in which the Christian bears witness to Christ in his professional life. Allowing those who surround him or her to know him or her as a male nurse or a female nurse who has entered the civilisation of love, he or she allows them to discover in their contact with him or her that one can be of this world and at the same time live in another place and live in line with a logic thanks to which the difficulties and the travails of current life are overcome. To be Christians does not liberate us from the evils which accompany the lives of each and every

person on this earth but makes it possible for us to liberate ourselves from them in a spiritual sense, dominating them by adopting a new approach which comes from attachment to that Lord of life who is Christ.

It can happen that the followers of Christ come to take difficult and painful decisions. These are an opportunity to demonstrate that the new logic into which the believer enters

cannot be reduced to an abstract discourse but is something which corresponds to reality and embodies it. Such are the origins of the counter-culture of which the Christian and the Catholic nursing personnel are the agents. It realises that the follower of Christ is not bound to the observance of prescriptions as though Christ had left his disciples a code or a ritual to be followed. The liberation brought by Christ is that of the conscience. It invites the individual to feel responsible for making the world more human through initiatives adopted in complete good faith. The Christian life is spontaneity. It is an answer freely given in full responsibility to the appeal made by Christ. The person who lives out these truths pushes others towards freedom. He challenges them to place themselves in relation to the gospel of Christ in the various situations in which they find themselves, discovering what their obligations are and judging the ways in which they should respond to them – for the Christian according to the teaching of the Church and for the non-Christian through accepting openness to the needs and the requirements of a civilisation of love. Seeing, judging and acting, to employ the words of Cardinal Cardijn, are the columns on which there rests every form of participation in the life of society.

The explanation of the Christian life which has been presented here corresponds to the reality of human life. Knowledge of it is not only explanation, it is also based upon experience. There is a communication through actions rather than speech. Our actions reveal the deep feelings which move us. A spontaneous reaction in the daily life of the professional is often an opportunity for the non-believer to perceive the depth in which a professional life is rooted. The person who wants to live as a Christian in his professional life must know that his daily forms of behaviour and conduct are also signs that he sends to those who are near to him and messages that he communicates to them.

It is necessary to examine the conditions in which the Catholic decides to write his imitation of Christ into reality. He does not fight for an alternative society proposed by a political programme or ideology but, like each and every man, as a prisoner of a set of conditions which weighs upon him, his task is to make such conditions 'more human'.[5] The Christian affirms that the criteria proposed by him are those which are most suitable to make the society in which he lives advance and he demonstrates that this is the right course not so much with arguments which are rarely accessible to those who work with him but with an appeal to that instinct for truth which is present in each and every individual and which directs him towards the good, the beautiful, the true, and the just. The Catholic professional discharges his obligations and in discharging them he strives to improve society according to his actual possibilities of doing so.

The Christian faces up to the encounter of his own faith with his experience of life in difficult conditions. These are new for him, immersed as he is in a pluralistic society. Forced to recognise the legitimacy of the position of others and the value that this position may have, he asks himself what the justification for his own faith is. It can seem to him that reasons alone or mere natural reason can take its place. Do we not today boast of the value of traditional cultures? Do we not give the impression that we put them all on the same level as that social behaviour which is based upon Christianity? In this way there becomes inserted in insidious fashion into the minds of our contemporaries the idea that before them a new epoch is opened up in which religions will no longer play the founding role which they have played in the past.

The Catholic professional is not the only person who wants to make society develop or wants it to stop on the road on which it seems to be travelling. The representatives of other social forces have the same ambition. The structure of the behaviour of both is the same. For both it is a matter of writing their representation of the ideal order of the world and their interpretational system of existence into reality. In this way the Catholic encounters other people who, without having his faith and his vision of the world, share his concern to give priority to the religious dimension of existence. He must live as a believer in a new context; for centuries his encounter with other visions of the world has been conflictual, and often violent. It was thought that truth was on one side and that error was on another. Both parties were in good faith when they condemned the other but they saw the solution to the conflict only in imagining a victory of one over the other. 'Truth above the Pyrenees; error below it', said Pascal. Greater knowledge of the human condition no longer allows us today to maintain this dichotomy. If every man and every civilisation are searching for truth, this means that they do not possess it entirely but only in part, and they do not manage to achieve it in

its entirety. All people have the same aspirations and these transcendental goods – the true, the good, the just and the beautiful – but they grasp them only in proportion to their spiritual elevation, their courage to concretise them, and their freedom of action. All people are the prisoners of the cultural inheritance that they have received given that they are not used to distinguishing in relation to it what is the essential substance of the contribution of history and are thus tempted to confer the same absolute across the board.

3. The Catholic Nurse and the Daily Realities of Existence

Four chief directional lines seem to influence the behaviour and conduct of Catholic health care personnel who wish to practice their own professional activity in a spirit of Christian witness. Two of these concern values, and the other two involve means.

Values

– *Respect for life*

Life is the most valuable good that man possesses but not everybody gives the same definition to it. For the Christian, life is a gift received from God, it is the moment at which every individual fulfils his personal destiny by conferring upon it a meaning. It is sacred because this faculty cannot be taken away from anybody because this would interfere between the conscience and God. Hence the rejection by Christians of abortion and euthanasia.

The struggle for life has today taken on a new breadth. The development of technology now allows us to dream of a profound transformation in the condition of human existence. Thus the habit of engaging in experiments on man, of cloning, of accepting mothers for hire, and post-mortem insemination...has already entered into the health care professions of certain countries. Such forms of 'progress', as some people maintain, have been facilitated by the fact that the nursing staff is today a part of a team which is itself an instrument of a policy defined from outside. That staff feels exonerated from responsibility towards itself and society; it no longer writes a transcendental end into its activity.

At the present time there is underway a struggle about the meaning of existence between the Church and the dominant currents of opinion of contemporary society. Catholic nurses know this – they have heard speak many times of the absolute opposition of the Church to a certain number of practices.

* A first question is that of knowing if every person has taken initiatives to change this knowledge into a conviction. Behind the offences such as those which have taken place in Cairo and which take place every day in clinics or laboratories, the civilisation of love of Christianity is called into question. It is not enough to say that all men are brothers, that they must help each other and love each other. We need to push this requirement to the very limits and see in every attack on life, however tenuous it may be, a limitation on the universal union of all men wanted by Christ.

* A second question is that of knowing what we should do to make our environment more respectful of life. We are not the only ones who see it as being something sacred, that is to say that it cannot be manipulated as we wish and reconstructed according to our ideas. Many other currents of thought believe that it has a value in itself, and it is on this terrain that we find ourselves. Our professional approach should reveal to them that their esteem for life can become deeper. They must learn through contact with us to discern how the new scale of values spread by modern civilisation favours or otherwise the development of life. The value of man does not come from what he consumes, otherwise he would have value only in relation to what he possesses or can purchase. The poor person, the handicapped, the unborn child, the elderly person... would see their right to life increasingly called into question when respect for them because a source of disturbance for those who hold power.

– *The Dignity of the Human Person*

The need for respect for life is not a slogan. It has consequences for the daily work of health care workers who are asked to strive to ensure that it is a reality for an increasing number of people.

It requires among other things that health care workers respect it in their professional life and do not abandon their right to make a moral judgement on their conditions of work and to live in line with this. The upholding of a status for the professional who is a conscientious objector springs from this principle. As the Declaration on Religious Freedom, *Dignitatis Humane,* lays down and specifies, nobody must be forced to act against the right prescriptions of his own conscience. We find a similar position outlined in the Universal Declaration of Human Rights of 1948.

In their work health care workers must respect the right of others to live according to the religious dimension of existence – they must ask themselves about their own responsibilities towards ensuring the provision of religious assistance to patients, providing the highest number of people with care and treatment of quality, and helping those with whom they are in contact to develop a sense of family – which is, indeed, the fundamental nucleus of society. In a few words they

must be filled with the idea that their mission is to lead those whom they encounter to a better understanding of their dignity and to grow in humanity. Health care workers contribute to this through their professional activity because this is a material, spiritual and psychological help for individuals and is at the basis of civilisation.

The Means

– *Commitment within Structures*

Service to life requires a person to take an active role in the development of suitable health care structures. Those who are engaged in care and treatment, whether they are in a hospital or do so privately, can know better than anyone else what is not going right in the health care services. They must point this out and at the same time work to modify the conditions in which they are called upon to take care of the patients.

Identity manifests itself in the concrete reality of occupations. We have to know how to discuss respect for life, good work relations, care for the very poor...but the Christian staff are those who are concerned with truth in their behaviour. They will thus ask themselves: in this situation what can I do and what do I do to promote life, to create the conditions for the receiving of life? Are the institutions in which I work sensitive to these concerns? What can I do on my own or in a group to maintain, defend or change the existing conditions? The health care worker is Catholic in proportion to the extent to which he is personally committed and can write greater benevolence into his own professional life through institutions.

– *In Particular through Professional Associations*

Active participation in the transformation of health care may appear a little utopian to a large number of health care workers. This objective is beyond the capacities of an isolated individual above all when he does not occupy a position of responsibility and he forms a part of a team engaged in providing treatment or pursuing research in which the tasks of each member are established without there being a possibility to take part in the definition of the general policy of the service which is provided.

This is not possible for an individual but it is possible for those who unite their efforts in order to obtain changes in institutions or practices. Sufficient emphasis can never be placed upon the importance of associations which are strictly professional in character in matters relating to health care and the duties of those who take part in the provision of such care. Such associations interpret the wishes and the claims of the ordinary workers. It is within them that the complaints about the poor functioning of the structures and the remedies which are proposed can be studied. They must remember that the aim of health care policies is the development of each and every man and of the whole man. But the philosophy of life that they spread is not, and cannot be, in a pluralistic world that which moves men and women who are religious. Isolated, they can do nothing. For this reason they must gather together in associations which can give them a voice.

The question of the collaboration of Catholic health care workers with non-Christians who share a vision which is near to theirs cannot be avoided. From various countries information is arriving to the effect that nurses belonging to religions different from the Christian religion are taking part in the activities of our associations. When such contacts take place these must be seen as an opportunity because they increase the possibilities of achieving our objectives in relation to sick people and because they make the member associations of the CICIAMS in this field the pioneers of a counter-culture of life. The need to represent religious aspirations can in this way be satisfied. Contacts with non-Catholics broaden the representative character of the CICIAMS at a professional level. Although its member associations are not organisations of a trade union character, they must strive to have an audience in the health care worlds where they represent the wish of most men to have the religious dimension of their existence recognised.

The question of the identity of Catholic health care workers is raised particularly in the societies of the twentieth century. They do not make faith in God the basis of their social institutions. In the answer which will be provided to them there is a need to define a new Christian culture, something which thirty years ago Vatican Council II defined through its Constitution of the Church in the contemporary world. Observing the new conditions in which Christians found themselves (or would find themselves) in order to be witnesses to Christ, the Council appealed for a deeper inner life in order to perceive the meaning of the dignity of man given to us by the Gospel in daily actions. This mission will be the mission of the third millennium. It pre-supposes, in order to be achieved, that Catholic associations will be strong minorities which will act within societies to help their members to uphold their faith in Jesus Christ and to communicate that faith to other people.

Rev. JOSEPH JOBLIN, SJ,
Ecclesiastical Adviser to the CICIAMS (International Committee of Nurses and Medical-Social Assistants), France.

Notes

[1] CARDINAL PAVAN, 'Attualità della Pacem in Terris', in F.BIFFI (ed.), *I Diritti Fondamentali della Persona Umana e la Libertà Religiosa* (Vaticano/Lateranense, 1985), pp. 149-154.

[2] The case of traditional religions is different because each of them does not constitute the *raison d'etre* of modern states.

[3] PIUS XII, radio message, Christmas 1956.

[4] A.DUPRE-LATOUR, 'Théologie des Religions Non-Chrétiennes et l'Islam', *Studia Missionaria*, 1999, 48, pp. 215-230.

[5] *Populorum Progressio*, §§ 19-21.

Challenges for the Third Millennium

1. Introduction

As General Secretary of the CICIAMS, it is a great pleasure for me to take part in this meeting and to extend to you all a warm welcome.

This is the first time that health-care personnel, and in particular nurses, obstetricians, and medical-social workers like ourselves, have been able to gather together in this magnificent hall of the New Synod in the Vatican.

I extend this welcome to you here in Rome, this magnificent, historical and central city of Catholicism, coming as you do from far away to participate in this important and indeed historic congress.

The whole world now looks forward to the third millennium and like a large number of other Catholic associations, the members and leaders of the CICIAMS have carried out a number of readings of the tasks and challenges of nursing during the third millennium. The member associations of the CICIAMS know their tasks and in general the challenges which they are faced by, and as Mons. Lozano Barragán observed during the Sixteenth World Congress of the CICIAMS held at Taipei in 1998, they know the *mission* and the *responsibility* of nurses, obstetricians and medical-social workers. At the end of his message, Mons. Lozano Barragán exhorted the CICIAMS to spread out wide, in particular in those countries where it is not yet present, so that the largest number possible of Catholic nurses, obstetricians and medical-social workers will decide to join it and so that the culture of life will shine forth in the field of nursing the whole world over.

The question which presents itself is the following: how can we apply this magnificent idea in the form of an effective and efficient strategy and how can we motivate our colleagues to adhere to, and to become members of, the CICIAMS? What is there that is new about the twenty-first century? Throughout the world those who provide health care find themselves up against monumental challenges. But this is something which they have always done, as indeed Dr. Shirley Dooling observed in Taipei in 1998.

The health of a nation is strongly linked to its economic status, to its health care policies, to whether there are conditions of peace, and to quality of life. The system of health care of a culture, society or nation is strictly connected to its values and its religion, and as a result to every change which might take place.

What, then, are the changes which mark out the twenty-first century?

1. An explosion in knowledge and information.

2. The development of technology, communications, and travelling.

3. The impact of the environment on individuals and on societies.

4. Changes in the role of women and the family.

5. New illnesses and infections (*Megatrends 2000:* J.Naisbitt and P. Aherdene, 1970).

How should the members of the CICIAMS face up to and tackle these changes?

As Rev. P. Joblin, the Ecclesiastical Adviser of the CICIAMS, observed in Taipei in 1998, we are invited to move from the second to the third millennium as though this was a sign of the challenges of the present time.

We members of the CICIAMS are invited to reflect upon our duties and to ensure that everyone of us moves from less favourable conditions of life to better conditions of life. We are called upon by the Pope to face up to the crisis of the sector of health care brought about by progress in the medical field. We are called upon to re-examine the traditional concepts of care and to adopt new values in our own cultures and societies.

We must face up to the pressures of public opinion and not accept technical and technological innovations without asking ourselves about their impact on human life. We must face up to the spread of values which compromise the dignity of man. The CICIAMS must have the courage to proclaim its own Christian vision of man.

Implementing and putting into practice all of this in the world of nursing constitutes what is certainly an important challenge.

The nursing and obstetric professions have acquired new importance, and technological and scientific advance have transformed them over a very short period of time (some twenty-give years).

Traditionally, nurses were the primary assistants of medical doctors but their image, and the image of obstetricians, has since totally changed. They no longer see themselves as assistants of medical workers but as part of their team, as their co-workers.

The contemporary tendency can no longer be halted. The world of nursing and obstetrics is face to face with an enormous challenge – that of unifying and supporting technical knowledge and capacities to being 'near', to care for patients, to commitment (which for some is vocation), and all this should be based upon Christian principles.

In recent years economic questions have become increasingly important in Europe, in Africa, in Asia, in South America, and in Oceania. It is more than evident that hospitals cannot survive if the economic aspect of things is not taken into consideration. However, economic realities are only applicable in a certain way – ethical and human considerations limit and constrain the economic approach. Health care workers have always been placed in front of an enormous task, and this will remain the case during the course of the next century.

Those who belong to the category of health care workers are privileged in the sense that they can put into practice such values as solidarity, generosity, and spirituality. In a secularised world they must behave like Christians, today and in the future, and this is something which is expressed in their professional and religious approach.

The authenticity of nursing will be the great imperative of health care workers in that such authenticity will be based upon the autonomy of nursing and upon its ethical kindness. Health care workers cannot be indifferent towards their neighbours and even less so towards those who suffer. Their neighbours call upon their real good will.

This has a price but man becomes better when he displays his goodness. In recent years health care workers have had to face up to great difficulties, and this will also be the case in the future, in relation to the work environment, social rules, and laws and other forms of interference on the part of public authorities. This is the case in every continent of the world. The authenticity of nursing also requires a development of a vision of management – we must become more involved at a direct level in the processes of care and treatment of patients and in organisation.

2. The Challenges of Nursing and the Lifestyle of the Twenty-First Century

a. The Specialisation and Fragmentation of Service in Health Care and Treatment

In a large number of societies and cultures being in good health is seen by many people as the greatest of blessings. The decrease in financial resources and a growing questioning in relation to the ethical implications of this requires greater thought and reflection. As an answer to this, we propose the creation of a health care system which is even more efficient and the creation of every type of medical and nursing specialisation. However, specialisation implies independence. Every form of specialisation functions with its own structures, its own way of thinking, its own methods, and its own forms of technology. The patient is no longer the central figure – this destiny falls instead to the specialist.

The specialist has become the central factor in treating and caring for the patient. He determines the way of thinking, the methods and the technology of health care. (An example: the pattern of self care of OREM, integrating nursing). The care which is provided must be supported by the activity and initiatives not only of the various kinds of health care workers but also by the patient himself.

Inter-professional collaboration has always been the most important characteristic and feature of team work. The patient is the central figure and indeed the very reason for the team's existence.

Interdependence is a third important concept.

b. The Position of Health Care/Obstetric Workers in a Multidisciplinary Team

The members of a team are able to work together at the same level in the interest of the patient to define the specific aspects of their profession at the interface of three worlds – as colleagues, medical doctors and auxiliary medical staff, and patients. The difference between these worlds are many in number when it comes to power, interests, knowledge, ability, and opinions.

b.1. Issues in the Relationships with Medical Doctors

a. The nursing staff are subordinated to the medical doctor in the professional and organisational fields. The nurse can at times act in an autonomous way in relation to the treatment to be administered to the patient.

b. The medical doctors follow the information about the care and treatment given to the patient and about the nursing staff. They must receive this information or insist strongly upon having it. This emphasises the importance of the position of the medical doctor.

c. The nursing staff are always 'near to the patient'. This approach is not limited to certain rites, and their field of action should always be very accessible in terms of what they have to do.

b.2. Issues in the Relationships with Patients

The patient must be seen as a 'regal client' and be the subject of care and treatment. There is a certain discordance in the position of the nursing staff in relation to the patient. They have to be emotionally and socially involved with the patient and have to take care of him or her at every moment of the day.

The nursing staff is not able to maintain that distance which is necessary in a professional approach. They run the risk of becoming too involved with their patients, of suffering stress, and the danger of mental wear and tear constitutes a very real threat.

b.3. Issues in the Relationships with Colleagues

Here stress and emphasis should be placed upon the method of nursing and the way

in which this method functions. There are two types of nursing, and these are different from each other. The nursing of tasks and integrated nursing. The nursing of tasks involves each person knowing his or her tasks and striving to perform them to the best of his or her ability or capacity. Integrated nursing involves each person acting as an autonomous expert, and, after a process of consultation, in co-ordinating those forms of care and treatment which should then be provided to the patient.

It sometimes happens that the nursing staff is not sufficiently involved with other members of the team looking after the patient, or that the cohesion of the team is not strong enough. Here the role of the head of the team is of primary importance. The method of leadership, based upon the group, is a favourable factor in the employment and utilisation of the health care staff.

c. Changes in the Concept of 'Human Care and Treatment'

What is care and treatment? In our times care and treatment is a concept, but it is also a practice. Care and treatment define the relationship between the medical doctor and the patient. It is a means by which to enter into a relationship in a certain set of circumstances.

As a result, the approach of 'care and treatment' in terms of a product of the market and of the 'patient' in terms of being a customer or consumer enters the picture. Care and treatment is a practice which is different in nature from business. To receive care and treatment is something which is different from buying a motor care. Care and treatment is a complicated process. The needs of the patient are central to this process and the patient participates in it actively. The goal is not profit or a product but a reduction of suffering and if possible the recovery of health. This means that in the provision of modern care and treatment there are distinct characteristics and changes, which may be listed as follows:

c.1. A Fundamental Ambivalence

On the one hand, we can see caring for and treating those in need as an essential value, an essential value of life and morality, something which is indispensable in a human society. On the other hand, since the eighteenth century, when in Europe care and treatment was above all else an act of philanthropy and then became well organised charity work, it has become a matter of professional activity. This kind of care and treatment has a fundamentally negative aspect in the sense that the patient is in a position where there is less respect for him and his dignity. How can this ambiguity be overcome?

c.2. First of all Changes without Human Health Care

a. Patients deciding on treatment.

In a large number of European countries (for example in Belgium and Holland) the patient himself decides the kind of care and treatment he will receive and a price for this is then agreed upon. The patients and their families, and this is especially the case in the geriatric field, purchase care and treatment in medical institutes and clinics, which, indeed, they themselves choose.

Specialisation and professionalisation of every kind in relation to those who provide care and treatment means that a large number of such people can co-operate in the planning and assessment of the various forms of care and treatment which are provided. The move towards this kind of contract for care and treatment is rapidly accomplished.

b. Changing the Business of Care and Treatment in Europe.

In Europe, hospitals, institutions, and health care centres etc. function in line with the mechanisms of the market. The provider of care and treatment meets the patient's demands and needs, although it should be stressed that these latter are at the centre of this approach.

c. Changing the Notions of Care and Treatment.

The moral vocabulary of health care workers has changed. Religious notions such as love, charity and respect no longer form a part of that vocabulary. Such notions are now individualised and are simply a part of the professional motivations of the nursing staff. Political notions have also changed: what has happened to quality and solidarity? This moral vocabulary and these notions are no longer applicable in politics. This is something which afflicts the approach of the nursing staff towards patients. The submission of the patient and his gratitude have disappeared. Today's norms and values are a complicated question, and the solution to things is to be found in 'engaging in ethics'. In this way, for many nurses, obstetricians and medical-social workers the leit-motif of the NVKVV (a member of the CICIAMS) is applicable, for example the difference between profession and vocation. Of what does this consist?

Profession requires that paid work is done by oneself in the best way possible; vocation involves performing one's work in a way which is based upon love, charity, and faith in the Holy Bible.

One can say that the leit-motif of the NVKVV is based upon the vision of the Nobel-prize winner Mother Teresa of Calcutta, but with this difference – all the members of the CICIAMS are professional people. It is more than evident that the idea of love-charity-faith is not in contradiction with professional care and treatment. They

are, rather, the basis of the fundamental values and approaches embraced by health care workers who are Catholics.

Before ending this section with ideas and proposals about the challenges for the human provision of care and treatment, I would like to return to the am-

biguity to which I referred above: care and treatment and the reduction in respect for oneself and the dignity of the patient. In order to clarify this ambiguity we must identify the two dimensions of care and treatment – care and treatment as activity and care and treatment as listening to the meaning of the human being. Health care workers provide human care and treatment, as the title of this paper makes clear. Care and treatment as activity has disappeared in Europe in recent centuries. In many cultures care and treatment is a holistic and integral part of life, and often connected to sacred activity. Care and treatment is a family question and thus the responsibility of all the members of the family and of sacred people. I refer here to almost all the societies of Africa, and to the previous systems of care and treatment in the Western world, in Latin America, and in Asia. Ever since the last century the health care systems of the Western world have defined care and treatment as an activity, and the provision of care and treatment is a paid activity.

The social sector, to which care belongs, occupies the third position in the Western world. Statistics and trends indicates that this will advance to the second position at the beginning of the next millennium.

Studies carried out in Holland show that 11% of the population in that country works in the health care sector, which is responsible for 11% of the national product. In Holland and Belgium, countries close to each other which have the same language and a similar culture, 60% of care is provided by women. One in three women between the ages of thirty and sixty provides care. These statistics include the professional and voluntary health care workers, and 20% of them receive a kind of salary which varies according to conditions of work, the ordering of the social system, etc.

We can conclude that in the West care as an activity is accepted as a framework of reference.

What has happened to care as listening to the meaning of human life? It has its roots in tradition. One is dealing with the realities of the ontological dimension of care, and this is something which means:

a) that human existence is incarnated existence;

b) that incarnated existence expresses itself in two ways, for example in vitality-passion, strength, energy in the face of fragility-dependency-vulnerability. All this characterises the human existence;

c) that care as listening is the mutual way of responding, engaging in dialogue, and communicating. It is fundamentally a social process because it is based upon the higher interest of the other person.

We can affirm that Mother Teresa, the poorest of the poor, well understood this fundamental basis of care – that it was, for example, a fact involving a permanent interest in the other person.

How can we, professionals of health care throughout the world, interpret the dimension of care as listening in the concept of care as activity?

1. The Goals of Health Care Activity

Often nursing staff direct their own activities towards dealing with dependency, vulnerability, illness, or poverty. Catholic health care workers associate care with the activity of individuals in order to give a meaning to people's existence, their illness, and their poverty. With Mother Teresa I refer to the pastoral letter *Salvificis Doloris* of His Holiness John Paul II.

2. The Responsibilities of Patients

In receiving care and treatment, patients express their sense of independence and of not being governed by other people, and can interpret their illness, handicap, age and even death as being a part of life. The dignity and responsibilities of patients must be incorporated into the provision of care and treatment.

3. Possible Options

The ethical care espoused by the philosopher Friedrich Nietzsche.

4. Poor health

A human being resists illness, handicaps, suffering and death. All of his energy is directed towards avoiding these attacks on life.

5. Good health

This approach does not involve a positive appreciation of suffering but allows it to be controlled. To dominate the fear of suffering establishes the conditions within which it is possible to ascertain and understand the value of life in all its expressions. What, speaking from a medical point of view, is a handicap, can from this point of view bring about good health.

When this view of health is accepted in medical practice and nursing there will be a place for an approach which links the meaning of care and treatment to the meaning of life.

To conclude this section on human care – all the nursing staff must find their own professional identity and their own profile must be the Catholic idea. I am referring here to what His Holiness Paul VI and later His Holiness John Paul II have upheld – a civilisation of love.

In referring to the Catholic health care institutions such as the CICIAMS, the strength of a professional attitude based upon Christian principles lies in an extraordinary mission. The Catholic professional organisations offer to the religious dimension an opportunity to have a valid place and to be integrated into the whole framework of health care and treatment.

3. The Emancipation of the Profession

a. The health care personnel must develop its own professional identity

A model of health care, such as integrated nursing, offers an opportunity which leads to the emancipation of the profession and to the demarcation of its own territory in relation to other health care workers.

a) The model which defends the patient in relation to the care and treatment which is offered is a response to the fragmentation of the health care system.

b) In their role as mediators, the nursing staff are the right hand man of medical doctors as well as being the advocate of the patients.

c) The health care staff must carry out negotiations, that is to say evaluate and assess its own work and the work carried out by other people.

d) The leaders of the nursing staff must combine two styles of leadership. One style should be directed towards work which brings about the good performance of the members of the team, their effectiveness, and corrects the limits to their autonomy. Another should be directed towards the person and should emphasise the mutual relationship which is present. The nursing/obstetric staff should help the patient to be as independent as possible. Health care and treatment require the staff to identity with the perspectives and points of view of the patient. This means identifying with what helps the patient in the life that he or she has chosen.

b. The Training of the Health Care Staff, Obstetricians, and Medical-Social Workers

Training must produce staff and personnel who are expert and fully qualified.

Not only knowledge, ability and capacities within the profession should be acquired. The basic principles of the professional contents of the other health care workers should also be absorbed. Knowledge of their own professional identity, and of suitable instruments of work, contributes to the autonomy and emancipation of the profession.

Health care workers must learn to be flexible in order to manage realities of employment which are always different, and be as effective as possible in all circumstances. During their training and their daily activity they have to deal with bioethical problems at all levels – brain death, the transplanting of organs, AIDS, etc. The time has come for them to develop their own ethical standards which conform to their own culture.

Nurses, obstetricians and medical-social workers must learn to listen to the human person. This is possible only if they pay attention in a systematic way to religious questions and realities. It cannot be expected that everybody will be able to hold a religious conversation but they should be able to find an opening through which to express religious questions and realities. The training of nurses and obstetricians should offer holistic references in which patients of every kind, including religious patients, can be helped.

The health care staff and personnel feel at times that it is not their role to engage in such things and thus they display little enthusiasm in openly expressing their own vocation. Christ said: 'the tasks are many but the workers are few'. His answer is still valid today: 'pray that the Lord sends workers to his tasks'.

Suggestions for the Education and Training of Nurses, Obstericians, and Medical-Social Workers

As Martin Luther King, the defender of civil rights, affirmed: 'social progress will never come on the road of the inevitable'.

How can we draw up a plan which can implement health care which is suitable to the third millennium?

The sector of health care must ensure a leadership which will allow us to shape and mould our vision of a better system of care. As Prof. P. Maraldo (USA) has observed, what we need, and what the world's nations also need, is a calm revolution in relation to health care throughout the world, which is conceived and implemented by the nursing staff. We have a great deal to offer to the world's health care systems. Nurses, obstetricians and medical-social workers must take part at all levels in the sector of health care.

This revolution must be calm because there already exist numerous theories and models which can revolutionise this sector. For some time health care has been provided to the poor – first it was provided by members of religious orders etc. and then by nursing staff.

We must offer a politically solid and implementable strategy in order to bring about a calm revolution. Prof. Maraldo (USA) suggests that in order to achieve this goal we must follow the following strategy made up of three points:

1. As nursing staff in the world we must first of all invoke what Thaillard de Chardin calls the Gospel of the human effort. We must develop in those who believe in Christ, and in those who do not believe in him, full awareness of the universe which surrounds us and in particular of our power to influence their development through our action. Our collective spiritual passion, which lays down that a world in good health must prevail, must be nourished and made systematic.

2. The nursing staff of the whole world has the responsibility to search in a forceful way for a professional status and jobs of independence, authority, and responsibility to accompany that status. Jobs of higher management, of executive functionaries, and of government will advance the paradigms and the models of nursing.

It is equally to be recommended that each nation engages in a re-evaluation and reassessment of the resources dedicated to its nursing staff. States must invest resources in education and the strengthening of leadership in nursing and obstetrics. Leaders must have a knowledge of the economics of health and the development and evolution of health care policies in order to contribute to a solution of the problem of human resources in their country, and to take on a role of consultation and management at the highest level of government and the private sector. Regional co-operation between the leaders of nursing (and in particular in developing countries where the groups of leaders are small and relatively isolated) is an effective and efficient strategy for the development of leaders in nursing in these countries.

An improvement in educational opportunities and in financial rewards, and a concern for the working conditions of nursing staff and obstetricians,

are important if we want to maintain a team of nurses all over the world.

Educational programmes in all countries must prepare students for work and supervise 'nursing helpers' who are responsible for formal, traditional and informal care such as assistants, healers, herbalists, families and friends.

The basic education of nursing must provide a general grounding. An advanced education in the form of clinical specialisation at a post-basic level given by the traditional programmes and by a 'from a distance' education is fundamental for educators and professionals.

There must be constant higher education for the nursing staff. This is also an instrument by which to achieve the progress of minority groups. Education is essential for the advancement of nursing.

Our nations increasingly ask for nursing staff who are able to provide a service of complex care and treatment. As a result, nursing education has reached a critical point. Education must be directed towards students more than towards an international health care plan. The nursing staff of every nation must open the road to ensuring that the prevention of illnesses becomes a priority.

Of essential importance, also, is an international policy of illness-prevention directed towards fighting drug and alcohol abuse, adolescent pregnancies, childhood mortality etc. Such a political policy of prevention would have an impact on fiscal and benefit programmes for employed people and the financial structure of the health care system.

A national policy of prevention would not only achieve what is obvious but would also improve the care and treatment, and indeed the well-being, of the nation, and would have the benefit of reducing the costs of health care.

3. As I.Perkins (Kentucky) has observed, for centuries we as nursing staff have demonstrated our skill and our commitment in relation to providing service wherever sick people have been encountered – in hospitals, at home, in schools, in the street, on battle fields, in the metro, and in our centres. We cannot, however, carry out a systematic reform on our own. We can educate other people, in particular our colleagues, and show them the path to the humanisation of care and treatment as a process through which a new and radical form of health care can be appreciated by everybody.

In educating other people in the humanisation of health care it is important to understand what health care really is. In the context of a new paradigm, health care is a positive emotional support and a response to the conditions and the situation of another person, a response which must uphold our commitment to their well-being, our concern, our sensitivity, devotion and patience. At the centre of care and treatment, as Callahan (1990) makes clear, there must be a commitment to never shift our gaze to abandon or to become uninterested in those who suffer, the handicapped or the mentally retarded, the alienated, or those who are afflicted by AIDS.

Our mission as nursing staff, educators, researchers and administrators, is the humanisation of the health care system through the humanisation of our Judeo-Christian values of justice, compassion, quality, management and co-operation with those we look after, our patients, our families, and our communities. In this process we will become a nation of healing people dedicated to reducing the suffering of all our brothers and sisters wherever they may be found. Is this not a part of our vocation as Christians? In order to apply the reforms which are necessary to the implementation of our mission we must help each other and in particular help our colleagues, the members of the other health care professions, to have the courage to see the face of Christ in the face of the congenitally deformed child whose mother uses crack, in the face of the young black man who is an alcoholic and cannot find work, in the face of a homosexual afflicted with AIDS, in the face of a woman who is homeless and mentally handicapped who sleeps in the tunnel of a metro beneath the city, in the face of a seasonal agricultural workers, in the face of a weak and lonely elderly person.

As H.E. Mons. Lozano Barragán has said, Catholic nurses, obstetricians and medical-social workers must be trained so that they can develop their faith within their environment and in particular within the ethics of nursing.

Catholic nurses must understand that their faith leads them to protect the basic principles of their professions, beginning with:

– the principle of benefit – always helping the patient;

– the principle of not doing wrong – never harming the patient;

– the principle of autonomy – leaving the patient to decide things on his or her own as much as possible;

– the principle of sincerity – the patient must be honestly informed;

– the sacred principle of life – human life must always be defended;

– the principle of justice – all people must be treated in the same way and receive what they have the right to receive.

Nurses, obstetricians and medical social-workers must address themselves to the sublime task of proclaiming the culture of life. They must show that life and care are a gift of God, which we must provide as such.

IV. CICIAMS: Catholic Organisations of Nurses, Obstetricians, and Medical-Social Workers

Origins and History

1928

In 1928, at an international meeting held in Basle, the presidents of the Catholic associations of various countries decided to create an international Catholic professional organisation.

1933

In 1933 the first congress took place at Lourdes and it brought together nurses from ten countries. On that occasion the 'study committee of the associations of Catholic nurses' was established. Its statutes were approved and the members of the committee were elected.

1933-39

From 1933 to 1939 the international committee extended its work to various continents of the

world and brought together under its banner a notable number of Catholic nursing associations.

1946

In 1946 the committee renewed its activities and spread widely in most of the countries where it was active. Faced with the complex development of preventive and social medicine, and the appearance in every country of qualified personnel in the medical-social sector, in addition to those engaged in nursing care, the committee decided to adopt the name of 'international Catholic committee of nurses and medical-social assistants' (CIACIAMS).

The Objectives of the CICIAMS

1. To encourage in all countries the organisation and development of Catholic professional associations in order to provide a moral and spiritual support to Catholic nurses (and nurses in public health), and to help them to advance their skills and expertise.

2. To co-ordinate the efforts of Catholic professional associations (with full respect for their autonomy) in order to study and express Christian thought in the professional world in general.

3. To take part in the general development of the profession of nursing and to promote health care policies and social well-being in line with scientific progress and in accordance with Christian principles, thereby ensuring the health and the well-being to which every human being has the right, and at the same time respecting the religious beliefs held by each and every individual.

The CICIAMS is governed by:

The General Council

The General Council is made up of the presidents or the official delegates of the member associations.

The Council of Administration

The Council of Administrations is elected by the General Council.

The International Secretariat

The daily questions are the responsibility of the International Secretariat.

THE NETWORK OF THE CICIAMS	
THE UNITED NATIONS/DIP AGENCIES: UNICEF WHO DIP ECOSOC ILO	INTERNATIONAL CONFERENCE OF ICO LONG-STANDING MEMBER OF THE PERMANENT COMMITTEE
COUNCIL OF EUROPE LAITY	PONTIFICAL COUNCIL FOR HEALTH PASTORAL CARE PONTIFICAL COUNCIL FOR THE PONTIFICAL COUNCIL FOR THE FAMILY

STRUCTURES OF THE CICIAMS

STATUTARY GENERAL COUNCIL

EXECUTIVE COUNCIL

EXECUTIVES
- INTERNATIONAL PRESIDENT
- FIRST INTERNATIONAL VICE-PRESIDENT
- GENERAL SECRETARY
- TREASURER
- REGIONAL PRESIDENTS

DAILY EXECUTIVE COMMITTEE
- GENERAL SECRETARIAT

REGIONAL SECRETARIATS

THE ELECTION OF DELEGATES TO:
WHO
UNITED NATIONS/DIP
UNICEF
ECOSOC
ILO
THE INTERNATIONAL CONFERENCE OF ICCO

COMMITTEES OF THE CICIAMS
THE TECHNICAL COMMITTEE
THE FINANCE COMMITTEE
THE STATUTES COMMITTEE
THE OBSTETRICIANS' COMMITTEE
THE PUBLISHING COMMITTEE

Activity of the CICIAMS

Congresses

International congresses are organised every four years. Regional congresses are also organised to study the health care questions and issues of each region in a more specific and detailed way.

Study

This is carried out by the technical committee and by various commissions in order to draw up reports and documents for members and international organisations.

Publications

The publication of the journal 'CICIAMS Nouvelles-News-Noticias-Nachrochten' and circular letters.

Participation

The delegates of the CICIAMS take part in numerous meetings and initiatives of the various international organisations with which it has connections.

The Solidarity Fund

Help to support, and participate in, the activities of the associations of Catholic nurses in developing countries.

Guides in Bioethics

Texts prepared and produced by the technical committee with the help of experts.

The Regional Secretariats

These have been created in:
AFRICA
The Francophone region
The Anglophone region
ASIA
EUROPE
NORTH AMERICA

Official Relations of the CICIAMS

The CICIAMS has official relations with the following intergovernmental organisations:

WHO
Consultative statute with the World Health Organisation since 1954

ECOSOC
Member of the Economic and Social Council of this body since 1954.

ILO
On the list of the International Labour Organisation since 1956.

UNICEF
Member of the United Nations International Children's Emergency Fund since 1956.

Council of Europe
Consultative statute Cat. II for social and health care questions since 1956.

The CICIAMS is a member of the International Conference of Catholic Organisations and has regular contacts with a large number of international organisations.

Future Activity

In order to meet the challenges of the year 2000 it is now necessary to react to the problems and difficulties faced by nursing staff.

a) Nursing staff must react and it is important for them to understand their own professional identity and for the Catholic idea to be emphasised and promoted for nurses, obstetricians and medical-social workers. To begin with we can refer to the words of His Holiness Paul VI and John Paul II on 'the civilisation of love'.

b) Collective reaction must be ensured by Catholic professional organisations, in this case the CICIAMS. More than ever before, the Catholic professional associations have an extraordinary mission as a driving and/or leading force of the professional skills and expertise of the members of this profession, and this is something which should be based on Christian principles.

During the Fifteenth World Congress of the CICIAMS, in September 1994, all the speakers laid strong emphasis on the fact that through the cohesiveness of groups and collective action ideas should be more strongly upheld through the professional activity of nursing staff, obstetricians and medical-social workers.

Catholic nursing staff, obstetricians and medical-social workers are not different from their colleagues when it comes to the question of professional skill and expertise. The quality of care and nursing differs according to societies and cultures. In industrialised countries nursing and the profession of obstetrics are of the very highest quality. Catholic professional organisations offer the possibility to the religious dimension of things to have a valid role and to be a full part of overall health care.

Although it seems difficult to motivate colleagues to become members of a Catholic professional association, the need to act together is greater than ever before because of the increase in secularisation and the loss of basic values.

The members of a Catholic professional organisation find the strength to continue their organisation but also the strength to help other people.

This is the essence of nursing and of the profession of obstetrics.

It is more than evident that all the members of the CICIAMS are aware of the fact that organisation is a part of the Church. The strong existing traditional link between CICIAMS, the Church and the Vatican must be maintained and even strengthened. The challenge of the CICIAMS is to differentiate itself from the other professional non-confessional organisations on the basis of Catholic principles.

Our vocation as a Catholic professional organisation is based upon the demonstration of faith and of attachment to the Church. This is what upholds the meaning of the CICIAMS in the world, today and in the future.

The CICIAMS must also meet the hopes of the single members when these seek a collective and public resolution of difficult ethical problems and issues, and in this it can bear witness to the greatness of God.

The organisations of the nursing staff united within the CICIAMS are an engine of energy at a local, regional and world level. They are:

– *places of encounter:* open to those who are interested in the humanisation of the health care professions. The concerns and reactions of other people should be shared in order to create a common awareness of the problems and issues of professional life and to contribute to this common awareness by beginning with the promotion of movements of opinion which can change our professional world.

– *Places of reflection:* friendship is important, it is the basis of every solid group, but it is not in itself sufficient. Catholic nursing staff need to reflect together on the problems and issues that they encounter in the exercise of their profession because the exchange of superficial comments is not enough. Facing up to the changes which are proposed and imposed, we must remember that a service of care which is really human must include the poor and the social integration of the victims of illnesses linked to drugs, family breakdown etc. and who are rejected by society. The associations of the CICIAMS must know how and when to speak about these problems and issues. To this end they will find in the social doctrine of the Church those teachings on which to base their commitment and the reasons behind the approach which we expect of them.

– *Places of prayer:* each and every association has its own tradition in this sphere which matches the context within which it has developed. This

must be conserved because it is essential for the members of the CICIAMS to acquire a familiarity with God which is suitable to them. This is an essential point. For this reason, we have an idea of God which helps a large number of sick people with whom we are in contact to discover the transcendental meaning of their lives, to assess their illness, and one day their death, mobilising all their spiritual energies and accepting the truth of their human condition. They will feel that they are the objects of an infinite love and for this reason they will have an infinite value.

– *Place of solidarity:* we say that Christians are united with those who are materially, psychologically and spiritually the poorest among us. Solidarity is the sign of our faith that we give to the world; it is our identity card. Our solidarity expresses itself by paying attention to the victims of life, to drug-addicts, or to the victims of AIDS. We are worried by the fact that such people do not have access to care.

Our solidarity goes towards families in order to make them stronger or to bring them back together again because our religious experience tells us that they are the basic structure of society. We therefore link them as much as possible to the forms of therapy that we exist to provide.

As we cross the threshold of the third millennium the member associations of the CICIAMS must face up to the challenge which awaits them. As members of civil society, they share its hopes but they also know that the path which is chosen is not always suitable. Their faith in Christ gives them a clear view of the transformations which are taking place in society. They do not seek to impose a model which should be applied as such to reality. They offer a catalogue of successes towards which every society should strive: human dignity, respect for the freedom of conscience, care for everybody, solidarity, a solidarity that unites the human fabric, which is very often destroyed by health care policies – all these are signs of the integration of the human masses into social and economic life.

With their eyes fixed upon God, the source of compassion and salvation for everybody, Catholic nursing staff will draw near to the third millennium aware of their mission.

The Gospel says that love, affection and care have a healing effect. Perhaps this is felt by the nurses, obstetricians and medical-social workers to whom courage to continue will be given by the Gospel.

AN VERLINDE
General Secretary the CICIAMS (International Committee of Nurses and Medical-Social Assistants) Belgium

The Identity of the Catholic Pharmacist on the Threshold of the Third Millennium

The subject which together we must examine and investigate does not require discussion or research about a particular problem which has arisen recently in the sphere of activity which we have been carrying out. Rather, it touches deeply on the existence of each one of us as a professional *man* in a qualified and sensitive sector of human society, having the free choice to live at one in Christ (cf. Gal 3:27) in a daily progression of conforming oneself to him always and everywhere (Rom 8:29).

I believe that those of us who are here, are here because we are convinced that the 'Great Jubilee does not only involve a series of tasks to be carried out but also a great experience to be lived. The external initiatives have meaning to the extent to that they are an expression of a deeper commitment which touches the hearts of people'.[1]

His Holiness John Paul II, in an insistent and unequivocal manner, has indicated the purpose of this extraordinary historical and spiritual event that we are now going through: 'Everything should aim at the primary objective of the Jubilee which is the *reinvigoration of the faith and the witness of Christians* ...to foster a strong wish *for conversion and personal renewal."*[2] Catholic pharmacists are celebrating the 'Great Jubilee' and the 'VIII World Day of the Sick' in communion with the sick and with those who dedicate themselves to the world of health and health care. In the message of the Holy Father they find well outlined the path on which they must travel, fully convinced of this providential opportunity which 'will see the Christian community committed to revisiting the reality of illness and suffering from the point of view of the *mystery of the Incarnation of the Son of God,* to draw from this extraordinary event *new light* on these fundamental human experiences'.[3]

Our meeting, therefore, will not be an exploration of 'you cannot, it's forbidden' etc. but a search for, and an encounter with, the *history of salvation,* the irruption of God who 'sent his only begotten Son into the world so that we could have life through him' (1 Jn 4:9).

We will follow the following points:

the meaning of what it is to be Catholic;

the promotion and the defence of life;

the Good Samaritan.

Before proceeding I would like to bring out the 'presence' of the pharmacist in Holy Scripture and the 'esteem' which the Church feels towards his profession.

In Holy Scripture

In the Book of Sirach one reads that 'The Lord created

medicines from the earth, and a sensible man will not despise them... And he gave skill to men that he might be glorified in his marvellous works. By him he heals and takes away pain; the *pharmacist* makes of them a compound... There is a time when success lies in the hands of physicians, for they *(physicians and pharmacists)* too will pray to the Lord that he should grant to them success in diagnosis, and in healing, for the sake of *preserving life'* (chap. 38: 4; 6-8; 13-14).

The Esteem of the Church

Because of the 'esteem felt by the Church' – something which is particularly important – I would like here to recall a thought of Pius XII, of venerated memory, who after quoting some verses from Virgil said: 'You belong to that truly worthy category of citizens who, consecrating time, intelligence, energy and the whole of yourselves to alleviating human misery, heal illnesses with treatment in a second and fend off, with wise and methodical prevention, those illnesses which threaten health. Yours is an onerous task because of the care which it requires and the responsibilities which it imposes. And yet your dedicated activity, distant as it is from the eyes and the applause of the public, confined to the recesses of a laboratory, silent and faithful witness to your demanding work, is as though it were veiled in silence. You lack those consolations which sweeten the so often harsh work of medical doctors and nurses when their patients and infirm are restored'.[4] And after saying that Christ the Redeemer was the 'physician of all humanity' he went on to say 'to you pharmacists he has commissioned in particular the theoretical and practical study of our bodies'. This esteem has been confirmed by the Popes up till now, and in particular it is pleasing to recall that John Paul II believes that pharmacists are 'evangelisers precisely because your profession presumes trust in your art and your humanity'.[5]

Being a Catholic

In the search for the words addressed by Popes to pharmacists over the last fifty years, we frequently encounter the appeal 'to be Catholics' in the carrying out of this professional service. John Paul II has been especially forceful in this regard: 'the forms of aggression towards life and its dignity are becoming increasingly numerous, in particular through the use of medicines and drugs, whilst in fact these should never be used against life, either directly or indirectly. It is for this reason that the *Catholic pharmacist* has the duty – in agreement, it may be observed, with the immutable principles of natural ethics proper to the conscience of man – to be a careful adviser for those who purchase remedies... For the *Catholic pharmacist* the teaching of the Church in relation to respect for the life and the dignity of the human person from his conception until his last moments is of an ethical and moral nature. It cannot be subjected to variations in opinion or applied according to shifting options'.[6]

But can there be a 'Christian medical science', asked Pius XII. And he answered this question in the positive in a broad sense 'not so much because of the science itself but because of the representatives and experts in which it exists, takes place and expresses itself'.[7] And in opposing the opinion of those who wanted to link it to mere immanent laws, Pope Pius XII observed that the receivers and the objects of every science do not exist in a vacuum 'but constitute a part of the universal world of beings; they are in permanent contact with the objects of other sciences and in a special way are under the law of the immanent and transcendent goal which binds them into an ordered whole'.[8]

Thus we come to the rub of the question. This is the worrying cross-roads of this time which ferries us from the end of one millennium to the beginning of another – the drama of the separation between faith and reason, which John Paul faces up to in *Fides et Ratio*, where he condemns the baleful abyss which awaits humanity.[9]

It is opportune to read here a passage which touches us in our professional activity: 'In the field of scientific research, a positivistic mentality took hold which not only abandoned the Christian vision of the world, but more especially rejected every appeal to a metaphysical or moral vision. It follows that certain scientists, lacking any ethical point of reference, are in danger of putting at the centre of their concerns something other than the human person and the entirety of the person's life. Further still, some of these, sensing the opportunities of technological progress, seem to succumb not only to a market-based logic, but also to the temptation of a quasi-divine power over nature and even over the human being'.[10]

The Catholic pharmacist is at the centre of the challenge, and he will find himself involved again in even more dramatic situations for his conscience during the course of the third millennium. At one in Christ one can observe with St. Paul 'nothing is beyond my powers, thanks to the strength God gives me' (Phil. 4:13). The strength on the basis of which one can face up to, and live, such situations is not rooted in ourselves but is to be found above us. *Technological man* does not know how, and is not able, to accept such a vision because he wants to examine and demonstrate everything *scientifically* and he thus falls victim to the temptation of feeling that he is *the real lord of this world.*

St. Paul, on the other hand, frankly recognises his radical dependence on God and refers to him in an absolute way. This frees a new strength which derives from the divine primordial strength of the Creation present in the universe. During his days as well there was a challenge with regard to the way of thinking about life, given that he writes: 'And you must not fall in with the manners of this world; there must be an inward change, a remaking of your minds, so that you can satisfy yourselves what is God's will, the good thing, the desirable thing, the perfect thing' (Rom 12:2).

The Catholic pharmacist who, in imitation of St. Paul, places his strength in the strength of Christ, will face up to the challenges of the *third millennium* courageously, with

consistency, and without apprehension. In this era of technology, and of the ancestral fear of who knows what unknown disasters the immediate future has in store for us, the Christian, open towards the *world,* and drawing strength from God, will faithfully carry out the creative mission entrusted to him by God. The Catholic pharmacist can well consider himself a 'helper of God' in the work he performs of restoring and reconstructing the '*sick man'*.[11]

Incorporated within the Church through baptism, Catholic pharmacists, like all Christians, 'are called upon to profess publicly the faith received from God through the Church' (*LG,* n. 11), and strengthened by the sacrament of confirmation with a strong presence of the Holy Spirit 'they are more closely obliged to spread and defend the faith as real *witnesses to Christ* in word and in deed' *(ibid.).*

Under the guidance of the Magisterium of the Church, Catholic pharmacists must accept 'not the word of men but what it is in reality – the Word of God' (cf. 1Thess 2:13) *(ibid.),* remaining incorporated within her not only in their bodies but also in their hearts (cf. *ibid.,* n. 14).

To be a Catholic pharmacist does not require a journey marked by fences and negative signs but a *reinvigoration of faith, a personal renewal* – even a conversion if necessary – to bear witness to the world that they believe in Christ the Saviour who assured us: 'if you continue faithful to my word, you are my disciples in earnest; so you will come to know the truth and the truth will set you free' (Jn 8:31-3).

The Defence and Promotion of Life

On the front of the defence, and the attacks on, life, the role of the pharmacist is not marginal but of primary importance, on a par with other roles which are equally dedicated to this essential good of man where encounter is not peaceful because 'the world of health care is a place of struggle for man where technology is tending to gain ever more space and does not always safeguard the rights of the person. Suffering, illness, and death are fundamental 'human' events, and the primary concern of everybody should be to collaborate with each other in order to solve their problems in a human way.

Helping the sick person to overcome his own trial with dignity is certainly the service which humanity expects from science, technology and pharmacology. But this will not be possible without a clear vision of absolute respect towards the human being who on his own transcends the value of all material realities. This is the constant point of reference which should never be lost from sight if we want to avoid consequences which degenerate into the tragedy of great social evils, the subject of your endeavours of study. In the Christian approach, man, created in the image and likeness of God, is the highest expression of the life of the universe. He is directed towards God and the universe is directed towards man. Just as the Creator of all things has placed in the secrets of nature hidden strengths to be discovered so as to draw from them the means by which to protect and develop life, so He has also written into the nature of man those principles of universal norms of behaviour which are not left to the subjective arbitrariness of interpretation or to variations in contemporary mentality'.[12]

Nine years before *Evangelium Vitae* John Paul II expounded the thought and the position of the Church with regard to this whole area that we are studying. From his words we can draw the following guidelines:

– The world of health care is a place of struggle for man.

– The rights of the person and his dignity are attacked by technology.

– Man is created in the image and likeness of God and transcends all material realities.

– God has written into human nature principles of human behaviour which are not subject to arbitrary interpretations influenced by the fluctuating current mentality, and in the secret of nature he has also written the remedies for his health (cf. Sir 38:4).

This is the reality of the challenges encountered by the Catholic pharmacist. The invitation to rediscover new light on these fundamental human experiences during the year of the Great Jubilee from the perspective of the Mystery of the Incarnation of the Son of God[13] requires consistent and coherent forms of behaviour – new light which *Evangelium Vitae* radiates widely with arguments of faith and of reason. This is a document which every Catholic working in the field of health and health care should have and whose contents he should study. I will now provide some outlines of those contents.

Life is Sacred and Inviolable

Any man who is open to truth and to good, if he sincerely listens to them, can, with the light of reason, reach the inalienable principles written into the nature of man. Indeed, St. Paul tells us that: 'As for the Gentiles, though they have no law to guide them, there are times when they carry out the precepts of the law unbidden, finding in their own natures a rule to guide them, in default of any other rule; and this shows that the obligations of the law are written in their hearts; their conscience utters its own testimony, and when they dispute with one another they find themselves condemning this, approving that' (Rom 2:14-16).

Now, one of the untouchable values of man which has always been perceived is *that life is sacred,* and that the right to this primary good is the foundation of every form of living together and of the political community itself.

For the believer in Christ this fundamental pillar of human society is erected into a sacred truth in the Mystery of the Incarnation of the Word of God which, as Vatican Council II puts it, floods 'the mystery of man with real light...also fully reveals man to man and makes him observe his very high vocation...with the Incarnation of the Son of God every man is in a certain sense united' (*GS,* n.22).

The historic event of our salvation revealed the infinite love

of God who 'so loved the world that he gave his only begotten Son' (Jn 3:16). And in the Son the life of every human person is raised to an incomparable and untouchable value (cf. *EV,* n. 2).

The life of man springs from the omnipotence of God – 'Let us make man in our image and our likeness' (Gen 1:26) – and it finds its sacredness and inviolability in Him. When the life of Abel was violated by Cain, God asked him for an explanation and condemned him with the following words: 'What have you done? The voice of your brother's blood is crying to me from the ground, which has opened it mouth to receive your brother's blood from your hand' (Gen 4:10-11).

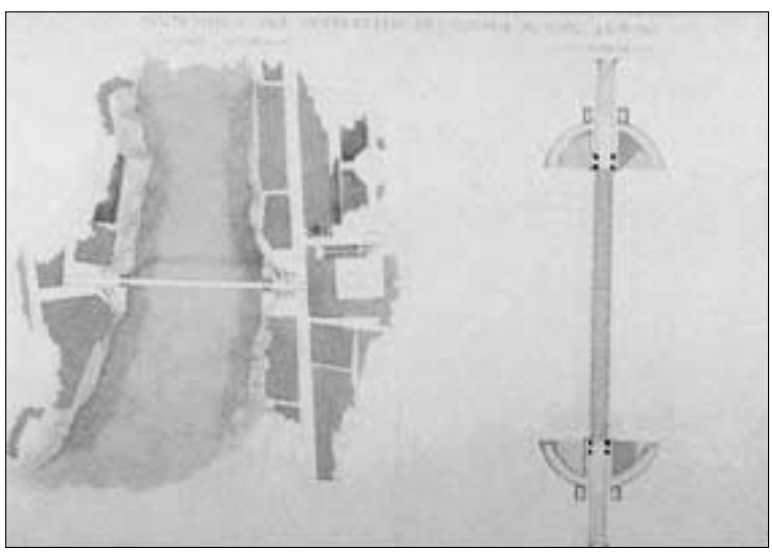
And after the flood Noah's absolute lordship was confirmed by God with the following words: 'For your lifeblood I will surely require a reckoning; of every beast I will require it and of man; of every man's brother I will require the life of man' (Gen 9:5), and the basis of this is in God 'for God made man in his own image' (Gen 9:6). God is the absolute Lord: 'I kill and I make alive' (Deut 32:39).[14]

In the Mystery of the Incarnation Inviolability from the Beginning of Life

During the never-to-be repeated historical occasion of celebrating two-thousand years since the Incarnation of the Word of God, the exaltation of the sacredness of still unborn life comes from the encounter between Elisabeth and Mary of Nazareth: 'Why as soon as ever the voice of thy greeting sounded in my ears, the child in my womb leaped for joy' (Lk 1:44). These are arguments of Faith, of accepting the revealed Word of God, which can make dialogue to an even greater extent something which cannot be communicated with those who are on the other side. One encounters those who proclaim 'individual freedom' which should be recognised and protected as a real and proper right, the absolute lord of his own life and of unborn life – this last being seen as a wrongful aggressor.

But 'reason' does not ask questions about the *absurd contradiction* of human society which at the end of the millennium which has just come to a close, while it boasts of having solemnly proclaimed the inviolable rights of the *person,* and the value of life publicly, and activates initiatives and promulgates legislation at a world-wide level to promote health and defend life, at the same time codifies the elimination of the *human person* at the beginning of his existence and justifies and protects those people who provide help in the carrying out of euthanasia.

How can the person who entrusts himself to reason alone, drunk with a Promethean approach, become master of life and death and decide upon them, when every day he accumulates defeats and feels the weight of a death without any perspective of meaning and hope?



Even with reason alone one can recognise that in man there is a natural law (see Rom 2:14-15) which convinces the political community of men that the foundation of living in peace without injustices and inequalities finds its unassailable foundation only in the recognition and upholding of the *right to the inviolability of the life which belongs to every individual member.*[15]

'Faced with so many opposing points of view, and a widespread rejection of sound doctrine concerning human life, we can feel that Paul's entreaty to Timothy is also addressed to us: 'Preach the word, be urgent in season and out of season, convince, rebuke, and exhort, be unfailing in patience and teaching (2 Tim 4:2)... we must not fear hostility or unpopularity, and we must refuse any compromise or ambiguity which might conform us to the world's way of thinking (cf. Rom 12:2). We must be *in the world* but not *of the world* (cf. Jn 15:19; 17:16), drawing our strength from Christ, who by his Death and Resurrection has overcome the world (cf. Jn 16:33).'[16]

The Good Samaritan

On of the objectives which the Holy Father indicates for this Great Jubilee is the rediscovery, and renewed witness to, 'solidarity-inspired welcoming of one's neighbour, especially he who is most in need'.[17] In his Message for this day he wrote to us: 'To those who are involved, either professionally or because of voluntary choice, *in the world of health,* I direct a warm invitation to fix their gaze on the Good Samaritan so that their service can become a prefiguration of definitive salvation and proclamation of new heavens and a new earth 'in which the just will have their fixed abode' (2 Pt 3:13)... The example of Christ, the Good Samaritan, must inspire the approach of the believer, inducing him to make himself a 'neighbour' to his brothers and sisters who suffer through the demonstration of respect, understanding, acceptance, tenderness, compassion, free self-giving...'[18]

The spectrum of the professional involvement of the pharmacist is wide and goes through various stages of research, of creation and production, in order to reach through distribution at a local ground level the pharmacy of the hospital and private practice. This last is a real and personal point of contact with the sick person.

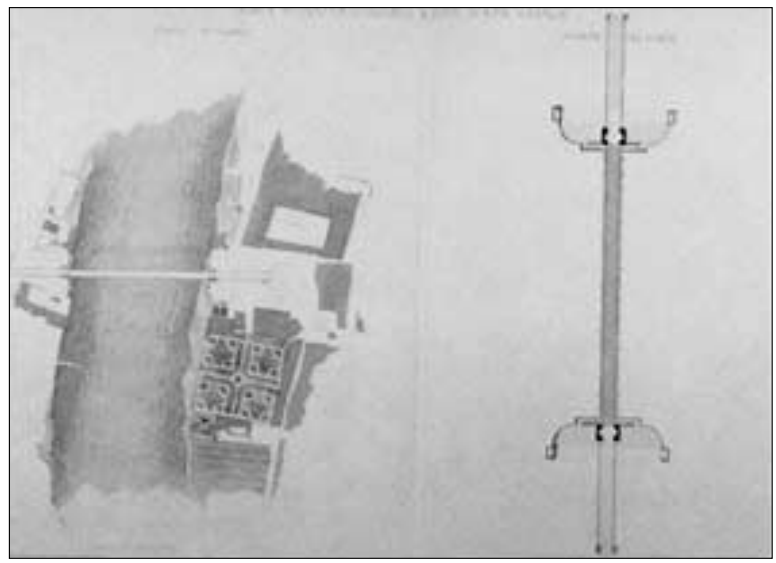
I would like here to turn our attention to the pharmacy to be found in the streets and the squares of our cities, without in any way, however, wanting to diminish the importance of those in the public health care structures and the private sphere, because I believe above all else that here the message of the Good Samaritan finds its greatest and most privileged form of application.

What I am saying is not something new but I would like to stress that a visit to a pharmacy generates an engine of tranquillity in the spirit and ensures that there will be somebody to whom we can entrust ourselves when there is need. It is like an anchor of salvation ready for possible unforeseen needs in relation to health. A secure point of reference in the area and for the foreigner who, in whatever capacity, finds himself in a land which is not his.

And in the small centres, where the hospital structures are outside the territory where people live, pharmacies are a 'life-saving' health care emergency centre. If we take it for granted that in these pharmacies the professional skill of the pharmacist is evident and high, it is to be hoped that he also dedicates himself to 'on-going training'. 'The pharmacist is, and must be, a professional of health. Given that he is in contact with citizens he can and must be an educator, an information provider, and a promoter of a *health care conscience* with suitable professional advice with regard to the taking of prepared drugs and medicines. And thus you understand what formidable responsibilities and immense moral problems your work involves, so that the pharmacy absolves with loyalty and nobility the aims of *its sensitive mission*'.[19]

Of the qualities referred to by the Holy Father the qualities of the Good Samaritan are not only to be welcomed – they are also a *'conditio sine qua non'*. And not only for believers but also for those who describe themselves as being *secular,* those who trust to 'pure reason'.

The individual present in the parable of the Good Samaritan of Jesus Christ is a heretic of his time from whom one could normally expect hate but certainly not obedience to the law of charity. Here the Divine Master wanted to exalt the law of *compassion and solidarity* written into the nature of man, and his action raised it to a *universal parameter* of *love for one's neighbour* (see Lk 10:29-37).



For the Catholic pharmacist Pope John Paul II indicates a broader horizon which has greater dimensions: 'Your work, however, is not limited to dispensing products destined to achieve physical-mental well-being. As Catholic workers, who work in the sphere of health care, you are called to play an important human, social and ethical role. Through contact with those who turn to your skills and knowledge you also have an opportunity to become advisers and even evangelisers, precisely because your profession pre-supposes trust in your art and your humanity. The moral and psychological comfort which you can offer to those who suffer is great if it is the fruit of a human maturity and a richness of values which derive from the immutable principles of natural and evangelical ethics. In this way you have an opportunity to add to your profession a dimension of authentic Christian solidarity, where the image of the Good Samaritan is present, which does not only offer immediate help but accepts the prospect of taking care of one's brother in the future as well (cf. Lk 10:29-37).

Dear pharmacists! The profession which you practice requires deep human, ethical and spiritual qualities. It requires wisdom and prudence linked to an alive sense of honesty and probity. Your workplace is not the video screen of a production chain where the commercial competition of industrial complexes is at work. It must be, instead, a place where suffering finds a remedy for the body and encounters comprehension for the wounds of the soul'.[20] Keeping present the 'image of the Good Samaritan' is to refer to Christ, who is the Love of the Father incarnated in our history. Love is the fundamental law of the Church and of the Christian. For this reason, it is in the Church, and for the Church it is always something of today, something always required, something always unfulfilled, something always subject to an encounter-conflict with the new challenges of the world. To be a *Christian* means *to be alive in the love of Christ*, and there can only be one life, that of love. Without love one cannot develop in conformity with Jesus Christ.

In a 'world which increasingly moves towards unifica-

tion' (*Gaudium et Spes*, n. 24), love for one's neighbour is of great importance for the development of peace and justice, and for the defence and upholding of the rights of the human person (see *ibidem*, nn. 25-32), and it is the sure way by which to 'find oneself again to the full through a sincere giving of oneself' (*ibidem*, n. 24).

'Every man is a Good Samaritan when he stops at the side of the suffering of another man, whoever he may be. That stopping does not mean curiosity but readiness to help. It is the opening up of a certain inner inclination of the heart, which also has its emotional expression. The Good Samaritan is every man who is sensitive to the suffering of other people, the man 'who is moved' by the misfortunes of his neighbour...

The Good Samaritan of the parable of Christ does not stop at mere consolation and compassion. For him these become a stimulus to actions which seek to bring help to the wounded man. The Good Samaritan, therefore, in definitive terms, is *he who brings help in suffering*, of whatever character it might be. And help, where this is possible, which is effective.

In such help he puts his heart but he does not stint on natural instruments. One can say that he *gives of himself*, his own 'self', opening this 'self' to the other person. We here touch upon one of the key points of the whole of Christian anthropology'.[21]

Here this paper must embrace the whole of the pharmaceutical spectrum. From industry to the point of the consignment to the recipient, that is to say the sick person.

On the same day as the release of the Message of the Holy Father for this *Day of the Year 2000*, the mass media give prominence to only one aspect, to be found in section 4: 'I am thinking in particular of the grave social inequalities in access to health care resources which are still today to be found in vast areas of the planet, above all in the countries of the South of the world. Such unjust unfairness affects, with an increasingly dramatic character, the sector of the fundamental rights of the person: entire populations do not have the possibility to employ even primary and urgently needed medicines and drugs while elsewhere people abandon themselves to the abuse and waste of even expensive drugs and medicines'.

A condemnation carried out by the media for its own sake because after this there did not follow any outline of the remedies which the Holy Father strongly indicates in his Message in order to solve these great inequalities. We ourselves take note of this and filter it through the *communion of goods* of the first Christian community.

The Acts of the Apostles tells us that 'All the faithful held together and shared all they had, selling their possessions and their means of livelihood, so as to distribute to all, as each had need'(2:44-45).[22]

This was the fruit of the sharing of the Gospel and all the goods received from God through Jesus Christ, as the whole passage well narrates. It was certainly not a mutual help limited to social elements, and even less the product of a *communitarian* ideology or a feeling of human solidarity. It was living God amongst them. Indeed, the attempt by the husband and wife Anania and Saphira to keep a part of the proceeds from the sale of an estate ended up with the dramatic death of both in front of the community which had gathered together – something which generated great fear in all of them.[23]

Their guilt lay in lying to the Holy Spirit through the Apostles out of a love for money. They had not adhered to the full to such communion in the Holy Spirit or perhaps they wanted to engage in a compromise between heaven and the world.

With the spread of the Church the *communion of goods* had to adapt itself – for obvious reasons – to increasingly new forms of expression. But it was always based upon the faith which 'the Holy Spirit, Himself unifying the body with his virtue and with the whole connection of its members, produces and stimulates charity amongst its members. And thus if a member suffers there suffers with him all the other members; if a member is honoured all the other members rejoice with him (cf. 1 Cor 12:26)... we share in the same charity of God and our neighbour and we sing to our God the same hymn of glory. All those who are of Christ, having the Holy Spirit, form a single Church and they are united amongst themselves in Him (cf. Eph 4:16)'.[24]

The Catholic pharmacist – from those who produce to those who hand over the medicine or drug to the sick people – who really wants to live the Great Jubilee is invited to 'revisit from the perspective of the Mystery of the Incarnation'[25] this mandate of the Lord 'of solidarity-inspired welcoming of one's neighbour, especially he who is most in need'[26] and ask the Holy Spirit to make him understand that 'a sign of the *compassion of God*, which today is especially necessary, is that of *charity* which opens our eyes to the needs of those who live in poverty and marginalisation...situations which range today over vast social areas and also cover whole peoples with their shadow of death.'[27]

The Church has always been sensitive towards the poor and has not failed down the centuries to call attention to this reality as well. The words of Pius XII may be quoted for everyone: 'We know how much acumen of intelligence is required by scientists for the accurate creation of medicines, how much long hard work your formulas require, how rare are the elements which you use. However, on the scales on which you weigh the drops of your medications place also the drops of the sweat of the people who in mines, quarries, workshops or in other hard work earn bread for themselves or their dear ones. Put the tears of parents ready to give everything in order to save their dear children from death, and ensure that your tariff on the goods is not heavier than what is right... You will forgive us, in truth, if something less sensitive has escaped our mouth: but it is our apostolic duty to be concerned with, and defend, indefatigably, the cause of the poor'.[28]

Our Pontifical Council held

its fourteenth international conference in November on the subject of 'the economy and health'. And its President, Mons. Javier Lozano, has published in recent days a book entitled 'theology and medicine' in which he dedicates the fourteenth chapter to the same subject. I invite you to consult these two weighty publications in order to gain a wider and deeper knowledge of what can be done today in this meeting of ours.

As has already been observed in this paper, the pharmacy has always been a centre of immediate health care. But in these requests and demands 'pharmacists can be called upon to engage in non-therapeutic ends which are susceptible to a transgressing of the laws of nature, and this to the harm of human dignity. It is therefore clear that the distribution of drugs and medicines – like their invention and their utilisation – must be supported by a rigorous moral code which is carefully observed. Respect for this code of behaviour pre-supposes faithfulness to certain intangible principles that the mission of the baptised and the duty of Christian witness make especially relevant to today's world'.[29]

Reference has already been made to the behaviour which the pharmacist must follow with regard to the defence of life. Here one should recall that being a Good Samaritan also implies an obligation of the conscience to safeguard one's own salvation and that of other people – in the full sense of the term, of the body and the soul. This is because 'the life which God gives to man is much more than existing in time. It is a tendency towards a fullness of life; it is the *seed of an existence which goes beyond the limits themselves of time*: 'if God has created man for incorruptibility; he has done so in the image of his own nature' (Wis 2:23).'[30]

Certainly, consistency with such a style of life produces by no means slight problems and complications in certain contexts and countries. It is not our intention here to open a debate upon such cases. We will recall simply that 'give to Caesar what is Caesar's and to God what is God's' (Mt 22:21) is profoundly rooted in the building of the earthly city, and one cannot exclude that it deserves to enter into the sphere of the working and associative plan of man. Man can attempt to achieve the blasphemous project of building a world without God but this will come back to hurt him.[31]

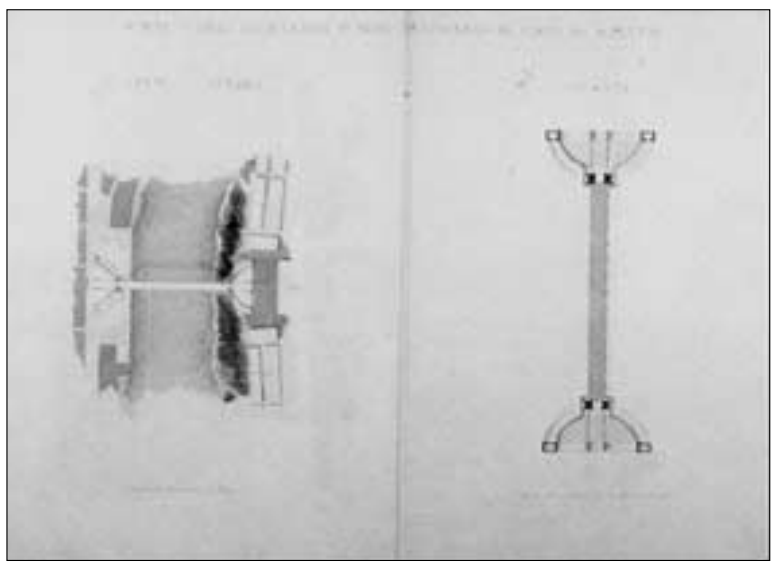
Conclusion

Certainly what has been argued so far in this paper is a language which is incomprehensible for those who do not have Faith. For the pharmacist who does not have faith in Christ and his Church what has been said here has no sense; indeed it is absurd and could give rise to approaches which are not very benevolent.

But we have presented these views for those who believe – for *the Catholic pharmacist* – and they are to be found in the vision of St. Paul who proclaimed the Crucified Christ and challenged the mentality of the *world*, always the same over time, because he strongly believed that the Cross is 'God's power. So we read in Scripture, I will confound the wisdom of wise men, disappoint the calculations of the prudent' (1 Cor 1:12-25). And we do not fear encounter. Even Paul at the Aeropagus of Athens felt dismissed with derision and with a fine 'we must hear more from thee about this' (Acts 17:32).

We should welcome the words of the Holy Father who tells us: 'nothing remains to me, therefore, than to warmly invite the whole Christian community to begin with ideals the journey of the Jubilee Pilgrimage... Everybody must anyway carry out that inner voyage whose goal is to detach oneself from that which in us and around us is *contrary to the law of God*, in order to enable us to encounter Christ fully, *confessing our faith in him*, and receiving the abundance of his mercy...[32] I thus invite pastors, priests, male and female religious, the faithful and men of good will to *face with courage* the challenges which present themselves *in the world of suffering and health*.[33]

Rev. FELICE RUFFINI, M.I.,
Under-Secretary of the Pontifical Council for Health Pastoral Care, the Holy See



Notes

[*] Paper given during the celebration of the Jubilee of the Sick and Health Care Workers, 9 February 2000.

[1] JOHN PAUL II, *Lettera sul Pelligrinaggio ai Luogi Legati alla Storia della Salvezza* (Vatican City, 29 June 1999), n. 1 (hereafter *PLS*).

[2] JOHN PAUL II, Apostolic Letter, *Tertio Millennio Adveniente* (Vatican City, 1994), n. 42 (Italian edition).

[3] JOHN PAUL II, *Messaggio per la VIII Giornata Mondiale del Malato Castel Gandolfo 6 agosto 1999, Transfigurazione del Signore*, n. 1 (hereafter *8GMM*).

[4] 'Udienza ai Participanti al Congresso Internazionale di Storia della Medicina, Castel Gandolfo 11 settembre 1954',

in S.E.R.Mons. F.Angelini (ed.), *Pio XII - Discorsi ai Medici* (Ediz. Orizzonte Medico, 6th. edition, Rome, 1960), pp. 342ss (hereafter *OM*).

[5] 'Udienza per il Congresso Nazionale della Unione Cattolica Farmacisti Italiani, Vaticano 29 gennaio 1994', n. 3.

[6] 'Udienza alla F.I.P.C per il 40.mo Fondazione, Vaticano 3 novembre 1990', nn. 3, 4.

[7] 'Udienza ai Membri della Unione Italiana Medico-Biologica di "San Luca" 12 novembre 1944', in *OM*, p.50, I (reference note 4).

[8] *Ibidem*.

[9] *Lettera Apostolica Fides et Ratio* (Vatican City, 14 September), 'Chap. IV - Il Relationship between Faith and Reason', nn. 36-48 (hereafter *FDR*).

[10] *Ibidem*., n. 46.

[11] Cf. 'Pio XII ai Participanti al Symposium sulle Malattie a S.Giovanni Rotondo, Vaticano 9 maggio 1956', in *OM*, p. 448 (reference note 4).

[12] 'GIOVANNI PAOLO II, Udienza ai Participanti del Congresso della Federazione Ordine Farmacisti Italiani, Varicano 26 aprile 1986, nn. 3-4'.

[13] Cf. *8GMM*, n. 1.

[14] See JOHN PAUL II, Apostolic Letter *Evangelium Vitae* (Vatican City, 25 March 1995), nn. 39-43 (hereafter *EV*). 15. Cf. *ibidem*, nn. 2, 15, 18-24, 45.

[16] *Ibidem*, n. 82.

[17] *TMA*, n. 42.

[18] *8GMM*, n. 9.

[19] 'GIOVANNI PAOLO II, Udienza ai Membri della Federazione degli Ordini dei Farmacisti Italiani, Vaticano 2 maggio 1981', n. 4.

[20] 'Udienza alla U.C.F.I. del 29 gennaio 1994', n. 3 (the reference is in note 5).

[21] JOHN PAUL II, Apostolic Letter *Salvifici Doloris* (Vatican City, 11 Feb. 1984), n. 28, (Italian edition).

[22] See also *ibidem*, n. 4, pp. 32-37.

[23] See *ibidem*, n. 5, pp. 1-11.

[24] *Lumen Gentium*, nn. 7, 49.

[25] *8GMM*, n. 1.

[26] *TMA*, n. 42.

[27] JOHN PAUL II, *Incarnationis Mysterium*, bull for the Great Jubilee of the Year 2000, the Vatican, 29 December 1998, n. 12 (Italian edition).

[28] 'Udienza ai Participanti al Congresso Internazionale di Storia della Medicina, Castel Gandolfo 11 settembre 1954', in *OM*, p. 346 (reference to note 4).

[29] 'GIOVANNI PAOLO II, Udienza alla F.I.P.C. per il 40.mo di Fondazione', n. 3 (reference to note 6).

[30] *EV*, n. 34.

[31] Cf. JOHN PAUL II, *Reconciliatio et Paenitentia*, the Vatican 3 December 1984, nn. 14, 18 (Italian edition).

[32] *PLS*, n. 12.

[33] *8GMM*, n. 15.

The Challenges for Pharmacists during the Third Millennium

This third millennium, which is about to begin, begins officially on the first day of January 2001, taking advantage, after a certain fashion, of this special year 2000, the Jubilee Year, the move to which has been opened up to us by the Holy Door, in a new Christ...

This Holy Year of the Great Jubilee must be for all Christians and for pharmacists in particular a year of celebration, thought, and reconciliation. To the joy of this anniversary must be added the hope of penetrating – so as to live it out and experience it in a better way – the mystery of God. Jesus is God's greatest gift to the world. We share this gift together in this anniversary, in the Great Jubilee of the Holy Year 2000.

How have we Addressed Ourselves to the Great Jubilee?

We have prepared for this Jubilee with the discovery of Jesus, the Son, the Spirit, and the Father. This is a path of love and triune contemplation.

Love includes forgiveness and reconciliation. Reconciliation can take place only in justice, solidarity, and brotherhood. This is the message of love of Jesus given to all men. We are loved and invited to love, to love each other, so that the history of man can become a symphony.

The Jubilee is a challenge, that of achieving reconciliation with ourselves and each other so as to draw near to our brother and our neighbour, and in particular to those who suffer in illness.

The year 2000 is a special year, *a year to remember*, and a year to prepare ourselves to live in daily life with the *Christ of yesterday, today and tomorrow*.

In the spirit of the Great Jubilee and the context of the third millennium, what are the challenges which pharmacists, and in particular Catholic pharmacists (who are particularly near to us), must address themselves to?

This Year of Reflection Must Direct our Attention Towards Certain Essential Points

– *The fact that we are children of God*

Jesus came to give us the possibility to be 'reborn' through water and the Holy Spirit in baptism, and in this way to be generated into the divine nature and life: 'What great love the Father has given us to be called children of God, and we are really such'(1 Jn 3:1).

– *Our hope*

In eternal life, in the contemplation of the divine, as children of God. The twentieth century has been a century of scientific progress but also a century of terrible events and developments which have generated scepticism in all contexts. *This Jubilee should be an occasion for the substitution of scepticism by hope*.

The year 2000 must be at the centre of our journey as pharmacists.

How have we prepared for the Jubilee? What work has been carried out to walk towards the Jubilee?

We have *sought to be inspired by solidarity*, not only by proclaiming the need for a remittance of the debts owed by the countries of the third world, and allocating the value of such a remittance to supporting and promoting *health and education programmes*, but also through *direct aid in the form of drugs and medicines* and help and support for many different countries: Bosnia, the Congo, the Cameroon, Burkina Faso, Ruanda, Poland... and a number of specifically targeted forms of aid and assistance.

It is in the spirit of illuminat-

ing saints, our patron saints Cosma and Damiano, that we must live out our solidarity with sick people within the tradition of the oath which we take as pharmacists.

We have become aware of the drama provoked by the absence of basic medicines and drugs and the damaging effects of counterfeit and false drugs and medicines which kill so many people in poor countries, and we are striving to develop a programme which will *ensure access to essential life-preserving drugs and medicines for everybody, everywhere*. Our joy will be very deep if we can achieve this before the end of the Jubilee Year. Such a hope is not groundless.

We have also *pointed out the risks and the dangers of experimentation on humans* where ethics do not exist. We have in the same way developed a series of ways of raising people's awareness and concern about the need *to elaborate bioethics* by which to defend the *dignity of the sick person* who is made subject to clinical experiments.

We have spread knowledge about the 'Charter for Health Care Workers' and the encyclical *Evangelium Vitae* both amongst pharmacists and the general public as well.

We want to give a *soul to health care workers, a hope to the sick*; we want to promote the Spirit of the Good Samaritan amongst people who treat and care for others.

Lastly, we have raised the awareness and concern not only of our pharmacists, but through the mass media also of every person concerned with *respect for life*, from its conception to its natural close, by providing clear and precise information on abortion, abortients, and euthanasia, and by *requiring recourse to the conscience clause* for all health care workers, including pharmacists...*Everything that becomes legal or technically feasible* (such as abortion, euthanasia, and clinical experiments, traffic in organs, etc.) *is not necessarily moral*. It is for this reason that the encyclical *Evangelium Vitae* proposes the *objection based on conscience*.

The challenge of the third millennium will clearly be marked by the actions and reflections of the past, but for *pharmacists this challenge will be multifaceted* and will concern the following areas:

– drugs and medicines;
– the direction of research;
– a positive approach towards the resources of local flora and pharmacopoeias;
– the ways by which drugs and medicines are supplied and made available;
– the training of experts in this field, that is to say pharmacists;
– an absence of discrimination towards sick people on grounds of race, religion, wealth, age, sex etc....
– the 'commercialisation' of the human person (cloning, transplants, the trade in organs, grafting, blood, spinal fluids, and so forth). This is a challenge for the field of ethics and bioethics.
– the demand for the recognition of the IFCP by the great international bodies.

The Challenge of Drugs and Medicines

This is, in paradoxical fashion, linked to the question of *access to all essential life-preserving drugs and medicines*. With twenty-five drugs we could solve the health care problems of 80% of the sick people of the world. *There is a great inequality which involves 15% of the population consuming 83% of drugs and medicines and the rest of the world, that is to say 85% of the population (five milliard people), having a 17% access to the healing powers of drugs and medicines*. By way of example, it may be observed that Africa has 11% of the world's population but receives only 1% of the drugs and medicines which are available in the world.

The question of 'orphan drugs and medicines' is becoming increasingly worrying and a source of concern. The bodies concerned with public health, the special foundations etc., should be concerned about the danger that people struck by rare diseases will be refused care in the form of the therapeutic means which are available. The principle of equality amongst human beings must lead to a rejection of these forms of discrimination.

Drugs and medicines produced by genetic engineering and invention are provoking very great hopes. But what costs lie behind these promises of success? And who will be able to meet these increasingly high costs which, in the case of European countries which have a highly developed system of social insurance, will have to operate within a context of an imposed reduction of expenditure?

Medicines and drugs for elderly people, following the increasing rise in life expectancy, will require trustworthiness and safety in order to add quality of life to quantity of years. The drugs and medicines of the third age are a challenge when it comes to maintaining cerebral vitality, independence, and the muscle-bone structure.

The Challenge of the Direction to be Taken by Research

The tendency continues to grow of concentrating the provision of benefits in increasingly narrow spaces. The concentration of pharmaceutical giants in concerns whose turnovers are greater than the budgets of a number of national states raises a number of important questions.

The direction of research into diseases and illnesses which afflict the population of the Western world, which is rich and able to finance expensive forms of treatment, will continue, and this will run the risk of further expanding the gap of access to drugs and medicines and of encouraging increasing forms of discrimination.

The increasingly high expenses of research and development will diminish the role of universities and centres of public research unless these latter are (partially) financed by the pharmaceutical multinationals. This will be mean that there will be a risk that basic research will be controlled in its direction and will thus lose its freedom. *The independence of research and development is another challenge.*

It is thus of primary importance that international institutions such as the World Health

Organisation, UNESCO and the Catholic Church raise their voices in favour of research being carried out into orphan illnesses and diseases and the production of high quality basic life-preserving drugs and medicines.

The Universal Declaration of the Rights of Man of 1948 declared itself in favour of access to health for all and access to scientific progress for all. The challenge of the third millennium will involve the implementation of these aspirations, and this is all the more the case because private foundations (Bill Gates, Rockefeller, etc.), which have enormous financial resources available to them, may well interfere in the path taken by research and development and in the enactment of humanitarian programmes.

The Challenge of the Positive Assessment of the Resources of Local Flora and Pharmacopoeias

The century which is now drawing to a close has witnessed the triumph of synthetic medicine and the end of this century (which is now leaving us) has established the bases for the new forms of biotechnology produced by genetic engineering. The contribution of these two branches of research is important and noteworthy, and a very large number of sick people owe to them either relief or their cure, or both.

Biomedicine is now making giant strides forward, but these must be evaluated and assessed in terms of morality and bioethical criteria, and for Catholic pharmacists such as we are this must be done in the light of the teaching of the Church's Magisterium.

But we must not, however, forget that ever since the world has existed man has found within nature remedies which he has adapted and made into preparations. The Code of Mammurabi, the Bible, and the voice of Ben Sirach the Wise, all bear witness to this fact.

Many civilisations still possess knowledge which is unknown to most people about the medicinal and therapeutic properties to be found in plants, minerals, and animals. The plant kingdom, the mineral world, and the animal kingdom, indeed, can still help us in the achievement of new pharmaceutical developments and discoveries.

Not only aspirin, quinine, curaro and the digitals come directly from nature. Recent drugs and medicines against maladies of the prostrate (serenoa repens, prunus africanus) and even against cancer (vincristine, vinblastine, platinum) come from the plant and mineral worlds, and others such as the enzymes come from the animal kingdom. Nature is still full of possibilities and the World Health Organisation suggests the implementation of research programmes to engage in a more effective exploration of the potentials of natural resources.

There are still species which remain to be discovered and drugs and medicines which can be taken from nature. Access to the knowledge of traditional medicine and the study of its remedies can enrich the treatment and therapy of tomorrow's world. Such treatment and therapy will be more accessible because of their availability and their economic costs.

The Challenges of the Ways by which to Supply and make Available Medicines and Drugs

Until a short time ago the sick person in the West purchased his drugs and medicines in a pharmacy, and an inhabitant of the third world – who could not of course come across pharmacies – went to the nearest clinic.

The medicine or drug which has become a pharmaceutical special object has left its places of official preparation, and for some 'charlatans' or 'merchants' it has become a source of quick and easy profit because of the credulity of sick people and their hopes of achieving a cure. Such practices can never be condemned enough.

To the usual official pharmaceutical circuit which guaranteed at the same time the quality of the drug or medicine and advice on its use, new networks have sometimes been added which have various kinds of consequences for patients and sick people.

Socio-economic obligations at times restrict the *freedom of choice of the sick person*. Thus in the United States of America integrated systems (research and development laboratories, systems of production, distribution, and direct supply, including hospitals and health care insurance companies) force those they help to obtain their drugs and medicines from within their respective systems. 'Privacy' (that is to say respect for private life, and respect for medical secrecy) and freedom of choice thus no longer exist. If the patient cannot find his drug or medicine within the confines of these systems he orders it (by telephone, by fax or by Internet) and he then receives it by post (mail order). This system does not act to defend the patient against the pursuit of profit, which is, in contrary fashion, the case with the pharmacist. The *health care risk* is increasing and is beginning to provoke a great deal of international reflection and concern.

In Africa sales networks of false, expired and counterfeit medicines and drugs are flooding the public markets. These are the so-called underground pharmacies which are also called street pharmacies. The same thing is happening in the bazaars of Asia and the Middle East. This is the kingdom of anarchy, deceit, fraud, and anti-public health.

It is therefore urgently important that the world of health reacts to this situation and that competent and skilled people – namely pharmacists – are organised into a medicinal ser-

vice of quality which is accessible to everybody throughout the world. While waiting to be able to have available a sufficient number of pharmacists in all the ACP countries, there is the good possibility of pharmaceutical missions for young members of our brotherhood who are interested in helping and promoting growth and development.

The provision of medicines and drugs must be like a chain where every link is safe in order to guarantee each patient the safety, effectiveness and quality of the drug or medicine which is employed.

The Challenge of Training

In addition to basic knowledge in chemistry, physics, analytics, galenics, pharmocodynamucs, pharmocology, pharmacotherapy etc., the pharmacist must also possess general and local legal and ethical knowledge.

Every pharmacist, in ideal terms, should possess knowledge concerning:

– communication with sick people so as to be able to listen to them in an effective way;

– health care economics or in pharmaco-economics in order to organise treatment which corresponds to the best cost/benefit ratio;

– local illnesses and diseases (infections, parasites);

– basic care and treatment;

– bioethics (respect for the dignity of the sick person whatever his or her physical or mental state may be);

– health care team work (medical doctors/nurses) where he can adapt his drug or medicine to the diagnosis which has been carried out.

For this reason, we recommend 'training schools' or 'schools for the application of pharmaceutical practice' for all pharmacists, not only with a view to permanent on-going training but also so that they can always serve their patients in the best way possible.

The pharmacist, who is an expert in drugs and medicines, should also become an expert in advising the patient so that he or she can gain access to the most suitable and accessible forms of pharmacotherapy.

The Challenge of the Equality of Sick People in Relation to Access to Forms of Treatment and Drugs and Medicines; Non-Discrimination

The Jubilee is an opportunity to remember solidarity. This must be lived out in the practice of non-discrimination towards sick people. In the West forms of discrimination already exist which are based upon age (for example in Great Britain beyond a certain age some drugs and medicines, or forms of treatment, are not the responsibility of the social state-administered health care service).

Some categories of sick people, afflicted by rare illnesses or maladies, do not have a right to the coverage of social care (for example in Great Britain those suffering from phenylketonuria).

The poor and the excluded do not always have access to care and drugs and medicines. We have recommended a minimal level of care for everybody because such access forms a part of the rights of man (cf. the ABPC/NVKA congress which was held at Ghent in 1998).

The figures on the differences between the North and the South of the planet and the West and the rest of the world are very striking. One sixth of the population consumes 83% of drugs and medicines whereas five-sixths of the population consumes only 17%! Discrimination also afflicts those suffering from AIDS, or those who are seropositive, and this is a fact which arises from the cost of the treatment involved.

At the time of the Great Jubilee of the Holy Year the Catholic pharmacists will offer to the Holy Father a symbolic gift and the bearer of hope for a thousand newly-born children. We will strive to break the chain of transmission of AIDS from the mother to the child by giving the Pope a new medicine – viramune – which acts to block this transmission, and we will do this with a view to saving innocent children from this fatal disease.

The final discrimination to be mentioned here involves the attitude of public services towards the physical or psychic, or mental, state of certain categories of people. We can now observe certain political regimes, certain nation-states, sterilise handicapped people, practice euthanasia on pseudo-incurable sick people, or make women who are in a 'state of need' engage in abortion on the basis of personal comfort, pregnancy tests, genetic tests, etc.

We Catholic pharmacists must proclaim the right to the respect of the differences between patients and to non-discrimination whatever the patient's age, sex, physical state, psychic state, psychological state, mental state, social status, religious loyalty, philosophical attitude, or socio-economic position may be.

The Challenge of Ethics

Side to side with the presence of conventional drugs and medicines, we are face to face with the development of therapeutic responses based upon the grafting of homologous or heterologous organs, surgery, transplants, attempts at cloning, and all the rest.

Tomorrow's pharmacist must reject the commercialisation of some or all of the human person. *As a subject the human person is increasingly becoming an 'object'*. The 'commercialisation' of, and the trade in, organs (eyes, kidneys, lungs), blood, and spinal fluids is enriching individuals who are people without scruples.

The pharmacist of the third millennium must uphold respect for the human person, his inviolability and integrity, the principle of non-commercialisation, the rejection of cloning, and also enlighten the patients on the risks run by all of us by the 'commercialisation' of others.

The Challenge of the Health Care Adviser

The pharmacist, that dispenser of drugs and medicines, will always have the role of being an adviser of the patient, not only with regard to the suitable use of the drug or medicine but also in relation to health care prevention, hygiene, small symptoms, self-medication, what drugs and medicines cor-

respond to, and so forth.

A training in the 'human sciences' will complete his training as an expert in medicinal matters.

In this challenge *for the Catholic pharmacist the challenge of his pastoral role* also enters the picture.

Among the many people who every day visit a pharmacy (the average number in the European Union is eighty) some have problems where moral and ethical considerations bear upon health care matters (abortion, euthanasia, serious personal or family illnesses). The Catholic pharmacist should add to his advice the evangelical approach of the Good Samaritan and should strive to implement *guidance*, an accompanying of his patient who is in a state of difficulty. *Recourse to pain-alleviating forms of treatment, within a specialised team, must form a part of the pharmaceutical response.*

The Challenge of Taking Part in International Bodies and Institutions for the Purposes of our Expert Testimony and our Humanitarian Action (the World Health Organisation, UNESCO, the Council of Europe, the European Union, OUA) will be one of our First Priorities

We have already collaborated with the genome project (UNESCO), the Convention of Bioethics (the Council of Europe), and the Charter of Bioethics for Africa (OUA). This challenge is important because over four hundred NGOs affiliated to the United Nations have signed a petition to ask for the exclusion of the Holy See as an observer member until it admits the case for abortion!

Conclusion

For the pharmacist of the third millennium there are a large number of challenges. Knowledge of drugs or medicines requires ever greater expertise, and this implies the need for constant training and an on-going revision of what the pharmacist already knows.

The new forms of technology will modify the usual pharmo-therapeutic spaces, and the management of health care risks will be give rise to greater worry and concern that is the case at the present time.

Paradoxically, research and development will be directed towards traditional pharmocopoeial remedies, and this is a course of action which has been suggested by the World Health Organisation. The future and the past, therefore, will constitute the present of the pharmacist of tomorrow.

His role within the state and the political community will be increasingly necessary so that orphan illnesses and diseases are not neglected and people are not excluded because of all kinds of discrimination.

Wherever and in whatever capacity he is to be found – the pharmacist in research and development, the pharmacist in the hospital, the pharmacist in the pharmacy, the pharmacist as a teacher, the pharmacist who holds the power of the administrative police, and the pharmacist as a biologist – the pharmacist must always be a *bearer of hope*. In the emblem of the Great Jubilee there is the cross, and this could be the cross of Christ the pharmacist.

The three arms of this cross remind us of the Trinity – the Father, the Son, and the Spirit united in love.

The emblem is in different colours. There is green, the symbolic colour of the pharmacy and of the IFCP. There is red, the symbolic colour of medicine, but also the episcopal colour and the colour of cardinals. There is the blue of female nurses, and there is yellow which, together with white, constitutes the papal colours. And finally there is the white of health care workers considered as a whole. The emblem, therefore, is also an emblem of physical and spiritual health dedicated to Christ and to men.

May this emblem, in the form of a challenge, encourage pharmacists (and other health care workers) to be actors of solidarity, of listening, and the bearers of hope for the sick people of the third millennium!

Prof. ALAIN LEJEUNE
President of the IFCP, the International Federation of Catholic Pharmacists, Belgium.

The Celebration of the Eighth World Day of the Sick in the World

During the Holy Year of 2000 the World Day of the Sick was solemnly celebrated as the Jubilee of the sick and health care workers.

In a special way in Rome, the culminating moment took place with the Eucharistic Celebration which was presided over by the Holy Father John Paul II on the parvis of the basilica of St. Peter's.

In the days immediately before 11 February, the date established by the Holy Father for this celebration, there were very special days, such as prayer vigils, the meetings with the bishops responsible for pastoral care in health in the various countries of the world, and the conference of the Catholic associations involved in pastoral care in health. In this publication the reader will find due weight given to this important event.

The World Day of the Sick was also celebrated in various parts of the world in different ways and in ways which took into account local customs, both at the level of health care

structures and parishes. Many religious, cultural and scientific initiatives which involved sick people and health care workers were organised and engaged in, and everywhere the presence of parish priests, hospital chaplains, nuns who work in hospitals, and voluntary workers, greatly helped to promote the strong sharing of prayer and the bringing about of a strong moment of spirituality.

The efforts made in some countries, such as for example Cuba, Ghana and Kenya, where difficulties of all kinds were encountered and which had to be addressed in order to achieve a successful outcome for the World Day of the Sick, are very much to be appreciated.

The Apostolic Nunciatures, like the bishops' conferences, engaged in a speedy diffusion of the Message of the Holy Father which was sent by this Pontifical Council on 11 February, the date chosen by the Holy Father to celebrate this day. The ready and concerned involvement of bishops, and in particular those responsible for pastoral care in health in the various bishops' conferences, ensured an effective raising of awareness in local health care structures.

An illustrative pamphlet with the title 'Curate Infirmos' was sent to the above mentioned religious authorities at the time of the celebration. This pamphlet was a support for the gaining of the Jubilee indulgence within the context of pastoral care in health, in the spirit of the Bull for the summoning of the Great Jubilee of the year 2000 – 'Incarnationis Mysterium'. In this pamphlet suggestions and ideas were given for visits to hospitals, to nursing homes, and to the home of a sick person living with his or her family, etc. so that, upheld by solidarity and fraternal communion, it would be possible, together with the sick person, to promote a spirit of penitence during a time so favourable to grace and blessing.

The pamphlet was distributed in a capillary fashion throughout the world and in some countries (for example Mali, Ecuador, Poland, Portugal and Hungary) this pamphlet was translated into the local language.

Numerous initiatives were also organised which were equally respectful of local traditions. Often, together with medical doctors, nurses and voluntary workers, the political authorities were also present, who thus wanted to emphasise the value and the importance of the suffering of sick people. Sick people also received visits, took part in meetings, were given presents, and therefore they, too, felt that they were real 'protagonists'.

It was also to be observed that some bishops' conferences pointed to the existence of intense co-operation with the parish priests who often helped hospital chaplains in the administration of the sacrament of the anointing of the sick or in the celebration of the Eucharist or vice versa.

In this paper we want to offer general information on everything that this World Day meant in the local Churches. For this reason, all the bishops' conferences were asked to provide a summarising account of their celebrations and the correspondence which we have received has been used to provide all the information for our readers, which now follows.

Naturally, for reasons of space, we cannot provide complete versions of the accounts that we received, all of which are equally rich and relevant. Furthermore, from some bishops' conferences we have not yet received detailed information. From others, such as for example that of Australia, the information has been of a general character given the complexity of the problem of obtaining information from the grass-roots. For this reason, we will confine ourselves to offering, if even only briefly, the news which emerges from the material which we have received.

North, Central and South America

Canada

A special kit was prepared in English and French containing the Message of the Holy Father for the World Day of the Sick, with liturgical observations and suggestions for the celebration of Holy Mass and special prayers to be said with sick people. This kit was speedily sent to all the bishops of the dioceses of Canada and all the Catholic hospitals and nursing homes in the country.

In the city of Hamilton the local association of Catholic doctors organised a special evening of prayer to coincide with the World Day of the Sick. A conference on elderly sick people was also held.

Colombia

The National Secretariat for Pastoral Care in Health printed a pamphlet on the Message of the Holy Father and this was sent to all the dioceses of the country. In another pamphlet, also the work of the section responsible for pastoral care in health belonging to the bishops' conference of Colombia, ten subjects for thought and reflection were presented as points of departure for possible discussion meetings.

On 12 February, at Bogotà, the first meeting of health care workers was held to define in a more accurate fashion their systems of training and to ensure that those who work in the world of health and health care see their work as authentic Christian vocation.

Cuba

The World Day of the Sick was celebrated in this Caribbean island with a great deal of enthusiasm, especially in the capital city, and was marked by three essential features: preparation, celebration, and follow-up. The celebratory part reached its culminating point with the Holy Mass presided over by His Eminence Cardinal Jaime Ortega, together with a large number of priests, at the 'Sanatorio de Rincòn' in Havana on 11 February. Over two thousand people were present, together with people who accompany the sick and health care staff and personnel. Religious celebrations took place throughout the country, both at a parish and a

diocesan level, often presided over by local bishops and always with a substantial participation on the part of sick people and those who accompany them.

The cultural side of things was also followed with care, with the organisation of local meetings on the training of voluntary workers and extraordinary ministers of the Eucharist. To give practical expression to the wishes of the Holy Father, concrete initiatives were also organised such as visits to hospitals and to places of care for elderly people. In this way an attempt was made to raise awareness and concern within communities and districts in relation to sick people, even though the difficulties which had to be overcome were not few in number. Reference, for example, should be made to the lack of means to hand for the preparation and the printing of information material and an inability to gain access to the official means of communication.

Ecuador

Throughout the country, both at a diocesan and a parish level, the World Day of the Sick was celebrated with great intensity and strongly-felt participation. At a national level a study-seminar was organised for health care workers in order to examine certain issues and questions of especial relevance, and in all the dioceses of the country the Jubilee of the Infirm had its most meaningful moment with the celebration of a Holy Mass by the diocesan bishops and the administration of the sacrament of the anointing of the sick to infirm people present in the churches. Lastly, many volunteer workers and priests engaged in activity to comfort sick people in their homes or in the various hospitals of the city.

The United States of America

According to the news we received from H.E. Mons. Charron, the bishop responsible for pastoral care in health in the United States of America, a very large number of dioceses and archdioceses of the country celebrated the Jubilee Day of 11 February in a solemn way, and in a way which respected different cultural traditions and locally spoken languages. The National Association of Catholic Chaplains prepared a kit with information material which was distributed to all the bishops of the country and to the national associations involved in the health care world.

Attention was also paid to the schools where an attempt (especially in the archdiocese of New York) was made to raise the awareness of students and teachers about the need to celebrate the World Day of the Sick as a moment of thought and reflection with and about sick people.

Venezuela

The celebration of the World Day of the Sick helped to further stimulate love and care for the infirm and also to make people understand the importance of the sacrament of the anointing of the sick as a sign of sanctification and purification. The World Day was also an occasion to carry out actions of solidarity, such as the taking to homes of food, shoes and clothes for sick people and their families. Unfortunately, the dioceses which possess few means of communication encountered a great deal of difficulty in promoting these kinds of initiatives.

Africa

The Ivory Coast

The solemn celebration was brought forward to Sunday, 6 February, and was held at Abidjan in the parish of the 'holy families' where a procession of sick people took place together with the people who accompany them, priests, and health care staff and personnel, who represented the other parishes of the city.

Beforehand, both the radio and the television provided capillary information on the event, with specific broadcasts on the subject, personal testimony, and interviews.

Ghana

A fine religious celebration was held in Abease, in the region of Brong Ahafo, with the participation of a large number of priests who represented the various dioceses. During the ceremony the poor people and sick children who were present were given medical treatment. The state television was present and broadcast the whole of the event on a channel watched very widely in the country. The director of the regional health services gave a speech in which he strongly appreciated the work carried out by the Catholic Church in every field of service for the poor and the suffering.

In the parishes of the dioceses of Navrongo-Bolgatanga an attempt was made to link the celebration of the Holy Mass with home visits to elderly people and the sick. In the Catholic clinic of Wiaga a representative of nurses spoke to emphasise to those present the importance of prevention and care in relation to certain fatal

diseases for children and invited mothers to follow the advice given to them to achieve greater hygiene in the environment and in relation to individuals.

In another large diocese of Ghana, Sunyani, the nurses of a large hospital of the city visited various schools and places of care in the outlying villages in order to bring practical help to very many families with sick people at home and to in-

struct families in how to provide care and treatment every day to their sick relatives.

In the 'St. Teresa' hospital special attention was given to future mothers, and in particular to very young mothers, through the organisation of an educational and prevention programme in relation to the most serious illnesses which can afflict expectant women.

In the diocese of Sekondi-Takoradi as well there was an intense celebration of the World Day of the Sick, with a programme which took place over a week (7-13 February) and which involved the active participation of health care workers, voluntary staff, and sick people. This was especially followed in the hospital of St. John of God in Sewi-Asafo, run by the Order of the Fatebenefratelli.

Kenya

The Message of the Holy Father was published in the newspapers and distributed in all the hospitals. In Nairobi, in the basilica of the Holy Family, a holy mass was celebrated for sick people and an attempt was made to raise the awareness of the dioceses about the importance of drawing up strategies of prevention and treatment for the most serious health problem which is now facing the country – AIDS.

Madagascar

The World Day of the Sick had an especially high profile because it coincided with the Holy Year 2000. In all the hospitals of the island encounters and events took place, of an ecumenical character as well, with sick people, their relatives, and health care workers.

The Secretary of the Commission for Pastoral Care in Health secured a broadcast by radio at a national level.

In Antananarivo, H.E. Cardinal Razafindratranda administered the sacrament of the anointing of the sick to a number of sick people. The chaplains of three hospitals, together with other priests from the capital, concelebrated at the event, and the Minister of Health, Mrs Rahantalalao, accompanied by a delegation of the World Health Organisation, also made a speech.

The Central African Republic

From the programme which we received one can observe the intense plan of meetings organised for various groups in order to raise the awareness of the ecclesial community as to the importance of sick people in the light of the Message of the Holy Father. The social mass media gave major space and coverage to the event.

On 11 February, in all the parishes of the archdiocese, liturgical celebrations were held, together with the administration of the sacrament of the anointing of the sick. In the cathedral of Bangui a solemn Eucharist was held presided over by the diocesan chaplain for the sick and in the presence of the Apostolic Nuncio, H.E. Mons. Joseph Chennoth.

Europe

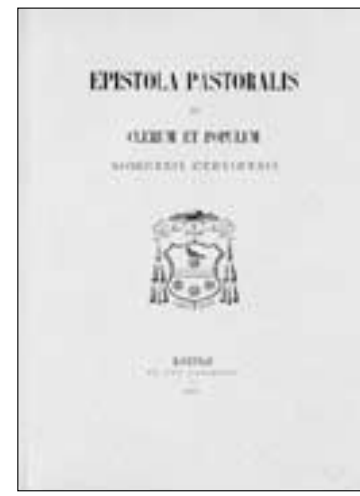
Georgia

On 11 February 200 the World Day of the Sick was celebrated solemnly in all the Catholic parishes after careful preparation which involved members of the various communities addressing themselves to existing problems. Special importance was given to the celebration of the Holy Mass which was held in the restored cathedral of the Assumption in Tblisi, Georgia. H.E. Mons Pasotto, the Apostolic Administrator 'ad nutum Sanctae Sedis' of the Caucasus of the Latins, surrounded by a large number of priests and in the presence of many nuns, presided over the Holy Mass and performed the sacrament of the anointing of the sick for a number of sick people. For the first time there was also a major presence of medical doctors and paramedical staff, both Catholics and non-Catholics. The World Day was prepared for with meetings on the subjects of the value of life, health, and the meaning of the Jubilee.

The participation of health care personnel and staff was intense and extensive at the meeting organised at the Camillian general surgery 'Redemptor Hominis' in Tbilisi. Members of the Georgian Caritas also took part in this meeting.

Ireland

'The Circle of Care' is the title of a book which was published in the diocese of Dublin to commemorate the Jubilee and it listed a number of different liturgical celebrations which had taken place in previous years, each of which was characterised by a different theme. The publication also contained certain additional



ceremonies which had been celebrated on special occasions. Every hospital and parish in the city received the Message of the Holy Father as well as a number of suggestions about the holding of various celebrations in order to involve the sick, the people who accompany them, and medical staff and personnel.

Italy

The celebration of the World Day of the Sick is increasingly being established as a strong feature of pastoral care in health in all the Italian dioceses and the various structures of the country. In the Jubilee year this was especially felt and the object of marked participation.

In a large number of dioceses the celebration took place in the presence of the bishop in the cathedral churches and in a number of Marian sanctuaries,

in addition to health care structures and the parishes. An attempt was also made to raise the awareness of all communities about the fact that 'in Jesus Christ suffering is redeemed'. With the supports prepared by the National Office for Pastoral Care in Health, the Jubilee of Health Care Workers was celebrated with sick people. Forms of 'adoption' by parish communities of sick people who were alone or in need, and of disabled people, were suggested as concrete gestures of solidarity.

All of the printed material (pamphlets, illustrative leaflets, and the Message of the Holy Father) was sent beforehand to the dioceses to help them to organise the World Day of the Sick in a more effective way.

In the official bulletin of the National Office for Pastoral Care in Health, news was published on the celebration of the World Day of the Sick in a number of Italian dioceses. Everywhere it was possible to see how the Jubilee of the sick was really a special appointment of the Holy Year 2000, something which further emphasised that our brothers and sisters in need are really at the heart of the mystery of Christ and of the life of the Church.

Belgium

The bishop responsible for pastoral care in health of the Flemish region, H.E. Mons. Vangheluwe, the Bishop of Bruges, observed that in Belgium there is no special day dedicated to the sick but he also pointed out that during the month of September, on the ninth and tenth of that month, religious celebrations and meetings are held in many parishes and hospitals in the country. However, the bishop, in an article which appeared in a local newspaper on 2 February, exhorted the faithful to follow the solemn celebration held in Rome and to join themselves spiritually to the Holy Father, perhaps by carrying out an action of love on the established day – 11 February – such as a visit to a handicapped person, to a sick or a lonely elderly person, and this with a view to gaining the Jubilee indulgence. The other bishop responsible for pastoral care in health, H.E. Mons. Lanneau, the auxiliary Bishop of Malines-Brussels, stressed that although not on 11 February itself, the Message of the Holy Father was nonetheless distributed in the parishes, and in the month of September a pamphlet was published with the title 'Listening to Loneliness'.

Luxembourg

The Catholic daily newspaper 'Luxemberg Wort', which is also the most widely read newspaper in the country, published for the occasion a special page on the World Day of the Sick which contained long passages from the Message of the Holy Father as well as the inaugural speech of the Archbishop, H.E. Mons. Fernand Franck. For over sixty-five years the Holy Mass celebrated for sick people has been broadcast by radio to the whole of the country and during the week of 11 February special space was given to this religious initiative.

Poland

An interesting and detailed paper was sent to the Pontifical Council by the archbishop responsible for pastoral care in health, H.E. Mons. Wadlislaw Ziólek, which describes a large number of initiatives, both at a diocesan and a national level, which were promoted in a way which sought to give emphasis to three specific elements: the religious aspect of the day, the cultural dimension, and the practical achievement of certain initiatives. The Sunday before the celebration of the World Day of the Sick homilies were given in a significant number of parishes on questions and issues connected with the imminent celebration. The sermon given by Archbishop Ziólek was broadcast live on the national radio channel.

Conferences and symposiums were organised for those responsible for pastoral care in health, and this was done in a special way in Poznan and Warsaw. In the capital city on 11 February, under the patronage of the Prime Minister and the Primate of Poland, Cardinal Josef Glemp, a conference was held on 'the dignity of man as a basis of the rights of the sick person and the patient'.

At a religious level it should be stressed that the preparation for the day was capillary and carefully organised. In hospital structures, and often in the presence of the local bishops, Holy Masses were celebrated with the administration of the sacrament of the anointing of the sick. *Vie crucis* were organised in many churches and places of care and treatment, and the blessing of the sick with the most holy sacrament was engaged in, along the lines of what takes place in Lourdes. Where possible, sick people were accompanied without charge to the various churches; otherwise, visits to the homes of the sick were organised, where the administration of the sacraments of the Eucharist, of reconciliation, and of the anointing of the sick was also organised.

The pamphlet 'Curate Infirmos', produced and published by the Pontifical Council, was published in Polish and distributed to all the health care centres of the country, together with a special publication of the 'Letter to the Sick' and various publications on the subject in the journal 'The Apostolate of the Sick'.

The World Day of the Sick was thus for the local Church an event which mobilised not only priests, those responsible for pastoral care in health, and sick people, but also a large number of health care workers, teachers, and workers. Participation was very extensive, thanks not least to the mass media which made the whole nation aware of the various initiatives which were being promoted.

Practical successes, the fruit of the generosity of members of the faithful, such as the purchase of a van with a machine for diagnostic tests, were also evident.

The Czech Republic

The Apostolic Nunzio, H.E. Mons. Coppa, was present in

one of the very few Catholic hospitals in the capital city to emphasise the goals and the intentions of this celebration, which had been called for with so much solicitude by the Holy Father. H.E. Mons. Coppa celebrated Holy Mass in the hospital/rest home for elderly people in Repy on the outskirts of Prague, run by the Sisters of Mercy of St. Charles Borromeus. In addition to members of the Order there were also present representatives of the sick, the director of the hospital, and the medical and paramedical staff and personnel.

The Republic of Slovakia

The World Day of the Sick was celebrated in solemn fashion in the two Marian sanctuaries of Sastin and Marianka, although the important event was observed in various ways in all the cathedral churches and in the parishes. In addition, on 5 February, the Auxiliary Bishop of Trnava, H.E. Mons. Stefano Vrablec, gave a talk on the importance and meaning of the World Day of the Sick during a nationally broadcast television programme.

Spain

The Department of Pastoral Care in Health of the Bishops' Conference invited all the delegations to organise a day of prayer on 11 February together with various groups interested in the field of health in the light of the Message of the Holy Father John Paul II.

Beforehand, three days of reflection and deliberation on the subject 'the word was made flesh' were organised for delegates and health care workers. The acts of these meetings were published in the journal of the Hospiteller Order of the Fatebenefratelli, *Labor Hospitalaria*, n. 254, 1999, and they were also distributed to all the diocesan delegates for pastoral care in health.

On the basis of this material, pamphlets and leaflets were published, in addition to prayers composed for the occasion, and these were distributed in a capillary fashion together with the Message of the Bishops of the Bishops' Conference for Health. Both the radio and the television took part with a large number of broadcasts and a live broadcast over the whole of the country of the Holy Mass held on 11 February.

Home visits to sick people and the elderly who had not been able to be take part in the religious functions were also organised, and in hospitals and nursing homes collective celebrations were held to administer the sacrament of the anointing of the sick.

Asia

India

'Jubilee – a call to renewal' was the subject chosen in India for the celebration of the 'Health Sunday and Healing Week' organised by the Commission for the Apostolate and Care of Health. The Message of the Holy Father was translated into the five regional languages of the country and was sent to all the dioceses, parishes and health care institutions. A fine poster on the chosen subject was also distributed.

Four regional meetings were organised for the co-ordinators of diocesan pastoral care in health, and an inaugural seminar was held in New Delhi. In addition, the celebration of the Holy Mass was for everybody, in various places, a strong moment of encounter and spiritual renewal.

Korea

An interesting and detailed report was sent to the Pontifical Council from the Korean Bishops' Conference, in which in addition to specific religious initiatives for sick people such as the administration of the sacrament of the anointing of the sick and the opportunity to engage in confession before listening to the Holy Mass, reference was also made to an attempt to unite the initiatives at a practical level – for example providing assistance and help to the infirm; helping them, at least for a day, to be well washed and well turned out at an external level; giving them

clothes and shoes; organising a cheerful moment with games; listening to good music; and watching films chosen for the occasion.

In this way an attempt was made to join spiritual relief given by prayer, by receiving and listening to a Holy Mass, with that relief provided by offering a World Day which was different for sick people, and for the health care staff and personnel as well.

To conclude this brief account we can say that from the news which has been received from the various countries it is clear that everywhere an attempt was made to put the person (especially if he or she is in a condition of illness and disability) at the centre of the World Day of the Sick, not only in words but also in facts.

We have tried to implement the words which the Holy Father John Paul II clearly enunciated in the Message which was addressed to all of us on the occasion of this Eighth World Day of the Sick: 'Just as the resurrection transformed the wounds of Christ into a source of healing and salvation, so for every sick person the light of the risen Christ confirms that the way of loyalty to God in the giving of oneself until the Cross is the winning way, and can transform the illness itself into a source of joy and resurrection' (n. 7).

Dr. A. CIATTINI
Official of the Pontifical Council for Health Pastoral Care, the Holy See.

Seminar Day on Leprosy 'Reality and Prospects'

Organised by
The Friends of Raoul Follereau Association of Italy - AIFO (Organisation for International Health Cooperation)
and the Pontifical Council for Health Pastoral Care

15 January 2000
The New Synod Hall
The Vatican

Opening Speech by the President of the AIFO

I must express my gratitude for this honour, which indeed is a very great privilege, of opening the deliberations of this special world day.

I should thank above all else the President of the Pontifical Council for Health Pastoral Care, His Most Reverend Excellency Monsignor Javier Lozano Barragán, because the practical realisation and bringing to fruition of this meeting has been the work of that Pontifical Council, and the taking on, the burden, and the weight of its organisation have been the responsibility of its President.

It is a very great honour for the Friends of Raoul Follereau Association of Italy, in this place and in the context of the Great Jubilee, to offer some important words and comments on the whole question of those who are afflicted by the disease of leprosy.

During the century which has just come to a close (at its beginning and for many years thereafter) the question of those afflicted by leprosy was a question which was little heard in this Western world of ours. Nonetheless, it was a very serious question. It was very serious because these sick people, who did not have any possibility of being cured, were above all else abandoned, marginalised – marginalised indeed in an active way – because their condition was considered a sacrilege, it was seen as being outside civic society as well as being outside religious society.

Follereau points this out in his writings: 'I have seen them in prison, I have seen them in concentration camps, I have seen them isolated'.

And the people who first took care of these victims of leprosy were the missionaries.

In their religious mission, meeting these people who were so reduced and beneath the lowest human condition,

missionaries looked after them through their mission, they lived with them, some of them also shared their lives and paid for this with their deaths, with self-sacrifice.

I would like to remember here the Blessed Father Damien who is also the protector of some of our associations which today are involved in looking after those afflicted with leprosy and who was declared blessed not many years ago by His Holiness John Paul II, precisely because after living amongst these leprosy victims in the conditions in which they found themselves from the outset, he fell ill from leprosy and then died as a result of this disease.

But together with him others have shared this self-sacrifice, this martyrdom.

And I believe that it is precisely these examples of sacrifice which built the foundation stones so that Follereau could launch his message and his campaign in favour of these sick people.

Follereau – the person who is our reference point – spent the whole of his life in organising and finding solutions to this very great problem. In this he was helped by science and an early medicine for this malady which had partial effects but which was nonetheless the first step on the road towards healing these sick people. Subsequently, this medicine was developed and made more incisive.

Today those who are afflicted by leprosy can recover from the disease. Indeed, they recover quickly, and they recover once and for all.

Today, however, the problem of leprosy is still not solved. Health care networks with health centres and professionally trained staff and personnel have been established in order to find sick people who are still in the early stages of the disease so that the subsequent mutilations which arise from the malady can be prevented, and so that these sick people are not further marginalised because of their mutilations and their forms of disability.

Today these organisations, these structures, have the support of civic society, of civic society at both a local and an international level.

Today, these beneficial new steps and initiatives for our sick brothers and sisters reach many of them and teach them very speedily.

At a certain point, the survival and persistence of many other situations of great difficulty, new diseases, hunger, and wars, rather diminished the level of attention which was paid to this subject. And this was also extended somewhat to our missionaries, who we have helped ever since the beginning of the creation of our association and with whom, as well, we have worked jointly.

Our association was born in Bologna and its first president was a Colombian missionary who was the special delegate of Follereau for this activity.

And today we find ourselves in the following kind of situation. Those afflicted by this disease are not many in number, they are not the tens of millions of individuals of some time ago. But they still exist. The tendency now is to forget about them.

What, then, is the point, the place, the opportunity by which to make a contribution to these realities, and a contribution which is beneficial?

We thought that this place, this Jubilee context, were the place and the opportunity.

And together we have been able to hold this meeting of ours where, if you take part in the various sessions, you will be able to understand the present state of the situation, the scientific state, and the social state, but above all else you will be able to understand that we must not in any way whatsoever close down the subject.

Many hundreds of thousands of individuals, some millions of people, still suffer from this disease, an affliction which has been forgotten by everybody and which everybody indeed tries to forget about.

We have made this choice, a voluntary choice to lend a hand to and help these people.

We want all those who are connected with and have relations with our brothers and sisters who suffer from leprosy to know that this problem must still be faced up to and tackled, to know that we want to address ourselves to it with the same will and the same readiness to help displayed by Follereau when he was alive, and by you now.

We want to inform everybody that the problem exists and that we want to solve it.

We only hope that all those who manage to hear us through these possibilities that we have to communicate will be with us, will help us, and will above all help our brothers and sisters who suffer from leprosy.

Dr. ENZO ZECCHINI
President of the AIFO,
(The Friends of Raoul Follereau Association of Italy)

Speech of Greeting by H.E. Mons. Javier Lozano Barragán

I greet all of you who have gathered together for this meeting which is fighting against the disease of leprosy in the world. It is fighting not only against the disease but also against selfishness, consumerism, and the worship of money which place many things in the front rank rather than dwelling upon where real values lie – in love for other people. This conference is taking place at the start of the Jubilee year, a year of grace, of forgiveness and of reconciliation, a year in which in visiting Christ in those who are most sick, most in need, and especially in lepers, we really increase charity, and increase amazed love when faced with the great mystery of the Incarnation of the Son of God, who mysteriously extends himself in lepers, in this period of Christmas, which is to be found precisely at the beginning of the third millennium.

We are all grateful for the great work carried out in the name of Raoul Follereau who in such an admirable way dedicated the whole of his life to effective care for lepers, and this to such an extent as to interest the whole of the world as never before in the fight against leprosy. Today Raoul Follereau is no longer with us, but there are his followers, the young people to whom he said: “And now it is up to you to fight, struggle, young people of the world. Be intransigent in relation to the duty to love. Do not yield, do not descend to compromises... Above all believe in the goodness of man. Because in the heart of each man there are wonderful treasures of love...”

Before dying Raoul Follereau uttered the following words: “I do not think that with my health I will see in the year 2000. That does not matter. I say to everybody: in making others happy become rich... the wealth which I leave you is the good that I have not done, which I wanted to do, but which you will do after me. Let my witness help you in this. This is my last wish, my will and testament. The greatest ill that could happen is this: that of not being useful to anybody and of not loving and serving anybody”.

This is true. He did not reach the year 2000. He died a Christian in Paris on 16 December 1977; lepers were on his lips and in his heart, a wish and a hope: “I want only one thing – that young people take my place!”

This is a reason for being present at this conference, for coming to continue the very great work of Raoul Follereau, to love lepers, to see how we can eradicate this terrible disease from the face of the earth. With reference to the solidarity of those not infected with this disease towards those infected with it the Holy Father John Paul II said: “they show that they grasp in an increasing way the dimensions and the serious-

ness of the question and with exemplary generosity they support public and private initiatives, and institutions and organisations, which are specifically dedicated to the fight against leprosy. Thanks to this tangible proof of solidarity and Christian charity it has been possible to limit in a decisive way the spread of the contagion even in those areas of high risk, and this to such an extent that it is now possible to envisage, at least on the horizon, the possibility that this disease will be finally and definitively defeated'. ('Message for the World Day of those Suffering from Leprosy Given in Cumura, Guinea-Bissau, Sunday, 28 January 1990').

We know how much medicine has advanced, and how today this disease is in practice treatable and also curable, and how in most cases it is due to the presence of dirt and an absence of hygiene. And we know how this group is a faithful follower of the apostle against leprosy, Raoul Follereau. The Holy Father John Paul II said: "For my part I will continue to proclaim to the world the need for greater awareness of the fact that through suitable help this disease can be effectively defeated. For this reason I ask everybody everywhere to support with ever greater intensity the courageous efforts which are made to dominate leprosy and effectively treat those that are still afflicted by this malady" (Manila, at Radio Veritas, when meeting a group of lepers from the leper colony of Rala, Saturday, 21 February 1981).

Thanks to the initiatives of Raoul Follereau today we are celebrating the world day of leprosy, and together with us it is being celebrated in one hundred and fifty countries throughout the world. This is an appointment which as the founder himself said is an 'immense appointment of love' which provides those who are afflicted with this disease, more than the notable material aid and help, with the joy and the pride of actually being treated as men.

I would like to finish these brief words with the exhortation which the Holy Father addressed to scientists and researchers concerned with Hansen's disease: "continue your research and your treatment, and be certain that the Church fully supports your work because, like you, she has received the commandment of Christ, written in the Gospel, to 'heal lepers', and she knows that the lepers who are healed are a sign of the kingdom of God (cf. Mt 10:8; 11:5). Help to build the kingdom of God, which is also the kingdom of humanity. Be dispensers of justice and love towards all those who, in the most desolate corners of the world, are waiting to receive the message of hope from today's society. May God bless you who are at the service of His people" (to the Pontifical Academy of Sciences, Vatican City, Friday, 1 June 1984).

H.E. Mons. JAVIER
LOZANO BARRAGÁN,
Archbishop-Bishop Emeritus of Zacatecas,
President of the Pontifical Council for Health Pastoral Care.
the Holy See

Speech of Greeting by Minister Rosy Bindi

I most willingly accepted your invitation because I believe that celebrating the World Day against Leprosy means to have the opportunity to engage in a wider reflection on the questions and issues of health, of the dignity of man, of justice, and above all to have the opportunity to reflect together on how the right to health is linked to fairness and on how leprosy may well represent a symbolic issue in relation to inequality in the world of health.

The 800,000 cases of leprosy which are presently to be found in the world are in large part attributable not merely to the problems or causes connected with the subject of health but also to poverty, injustice, and the marked inequality which still characterises the world and the relations between the peoples of the globe.

At a simple level these 800,000 active cases which are to be found in the world could be eliminated if there were a political commitment to use the resources which are available to us in a correct way.

And how can we not remember the words of Raoul Rollereau: 'we can eliminate leprosy in the world for the cost of a bomber!'?

It has been demonstrated, furthermore, that leprosy can be defeated.

The striking success of the WHO's anti-leprosy project bears full witness to this.

Today we have new instruments to hand by which to heal this disease and avoid future contagions.

These instruments, which are the fruit of research, of the commitment and endeavour of institutions, of the scientific world, of the medical-health care world, and of the world of voluntary work, allow us to believe that the eradication of this disease is near to hand.

The protagonists of this battle, as I mentioned earlier, have been many in number; and these results have also had a large number of protagonists.

But it is certainly the case that it is voluntary work which has been, and is, the chief protagonist in the struggle against leprosy.

The Church has always been in the front line against this disease, and above all religious and secular associations; the experiences involving success which has been achieved

thanks to the commitment and endeavour of the world of voluntary work have been very many in number.

Your association is perhaps the clearest and most limpid example of this, not least because of its capacity to believe that leprosy is a symbol of the inequality which exists in the world of health.

And it is precisely from this sensitivity which joins together the commitment and endeavour of institutions, of the scientific world, of the Church, and of voluntary work, that perhaps comes the ability to overcome the principal obstacle. This obstacle is to be found in the lack of a real international commitment on the part of rich countries which have been able in large measure to defeat this disease in their territories and which must today commit themselves to achieving this objective throughout the world.

This is because, once again, leprosy, together with other diseases, is an evident sign that either we manage to defeat it, and to defeat it throughout the world, or the battle is not really won at a deep level.

Of crucial importance, therefore, becomes the mobilisation of people's consciences so that the subject is not forgotten about, so that resources are mobilised, and so that the attention of governments is directed towards this fundamental problem of fairness in the world of health.

For some time Italy has been in the front line in the fight against leprosy, as I believe is testified to here by the commitment and endeavour of the co-operation of the Ministry for Foreign Affairs, in addition, naturally enough, to those many people who adhere to the Raoul Follereau Association and other voluntary associations.

In addition to working in countries where the incidence of this disease is high, Italy has been, and is, committed to fighting against those small outbreaks of leprosy in our own country, the remnant of a past which was often badly managed but which today is augmented by new cases


LE SCIENZE E LE ARTI

DI PIO IX

PARTE PRIMA

ROMA

which come from countries where this disease is widespread.

Once again the great migratory glows remind us that either the battles are won throughout the world or in the long term each one of us, in one way or another, is called upon to share not only the results but also the defeats.

Recently the Ministry of Health has drawn up new guidelines for the monitoring and control of Hansen's disease.

This has been done with full respect for its own institutional rules and regulations and in co-operation with the various and complex responsibilities of the Italian national health service, above all in the special administrative regions of the country.

But this has also been done always and at all times bearing in mind the epidemiological and scientific data which are present in relation to the world as a whole.

The characteristic elements of these guidelines are the definition of the disease and its clinical data, diagnosis, the management of those who are afflicted by it, the groups at risk, prevention, epidemiology, and the monitoring of its development. At the present time, because of the increase in the number of cases which have emerged in recent years because of the migratory flows from countries where this disease is still well rooted, a new measure is being implemented for the creation of special regional centres and a real and authentic surveillance laboratory dedicated to looking at the arrival of new cases.

But the Italian health service, which has been recently reformed in order to be nearer to, and more effective for, the ordinary citizen, above all else wants to be characterised in addition by the taking on within its own confines through great national solidarity of an even greater commitment to ensuring that the right to health is really respected throughout the world and to ensuring that all forces – including those of institutions, of society, of the Church, and of States, come together to fight all the causes behind this scourge and to obtain those results which we all hope for and would like to achieve.

I can remain with you only for a few more minutes.

I want, however, to stress once again the importance of this day and the importance of the way in which you have sought to celebrate it – with a meeting of reflection, study, investigation, and the exchange of experiences. To all of this we look with great interest and we believe that the results of this day will be valuable, and all this so that we can perform our task to greater effect.

Thank you all.

ROSY BINDI
Minister of Health.
Italy

The Raoul Follereau Association of Benin (ARFB)

Within the framework of this prestigious meeting, whose participants I here greet with great respect, I have been asked to present a paper on the Raoul Follereau Association of Benin (of which I have the honour to be President) and on similar associations to be found in Africa.

1. The Association

The Raoul Follereau Association of Benin (ARFB) was created on 28 March 1968 at the instigation of the French Raoul Follereau Association, and was registered at the Ministry for the Interior on 16 November of the same year.

2. Organs

The following organs make up the Association:
– the General Assembly;
– the Council of Administration;
– the National Executive Office;
– the local committees.

All the members of the National Executive Committee and the Council of Administration – people who come from different contexts – are volunteer workers.

Only the secretary, the driver, the rural supervisor, and the consultant accountant receive salaries.

3. General Objectives

1. To promote the socio-economic reintegration of people who have been cured of leprosy.
2. To support the action of public authorities or private bodies in the struggle against leprosy and all the great social evils suffered by Benin, and in particular Buruli's ulcer, a new emerging illness.
3. To initiate and support all projects of community development, in particular in the field of food self-sufficiency, hygiene, and education.

4. Areas of Interest

– Those suffering from leprosy and above all those who have been cured of leprosy.
– Buruli's ulcer for which this year a treatment centre at Allada will be established in the department of the Atlantic, in the south, through our principal collaborator of the north, the Luxembourg Raoul Follereau Foundation.

5. Sources of Finance

– the subscriptions of members;
– gifts made over at the time of the World Days of Lepers;
– grants given by the Luxembourg Roaul Follereau Foundation for the drawing up and implementation of projects.

6. The Partners

– the Luxembourg Roaul Follereau Foundation which provides grants and financial support, as has already been pointed out, and which has given us two 4x4 vehicles for our trips around the country;
– the French Raoul Follereau Association which has given us material for the World Days of Lepers, that is to say calendars, posters, works of love, Raoul Follereau postcards, and charity boxes.

7. Collaboration

– in the South this takes place principally with the sister associations of the sub-region, and in the North with the UIARF (the International Union of Raoul Follereau Associations to which we belong);
– the French Raoul Follereau Association;
– the Luxembourg Raoul Follereau Foundation.

7. Activities

At the outset these were very difficult and on a small scale because of financial and logical reasons, but today our activities display a certain vigour.

For three years, thanks to the logical means which we have acquired, local committees have been created at a ground level, and at the present time there are eight of them. Thanks to these local committees, which are departmental copies of the National Executive Council which once had ubiquitous control, there is now a happy division of work which in turn brings about more effective action in the field.

In addition to the annual General Assembly and the statutory three-monthly meetings of the Council of Administration, the management of the business of normal administration and the implementation of activity are guaranteed by an office limited to five members from the National Executive Office. This smaller office is required to meet once a week. Our activities are engaged in throughout the whole year and include the following principal initiatives:
– visits to centres for anti-leprosy treatment to which every year gifts are sent within the framework of the World Day of Lepers;
– the launching and supervision of projects and microprojects entrusted to groups of people cured of leprosy who manage them through co-operatives;
– the training of members of the offices of local committees and patients involved in projects and microprojects such as: agro-pastoral farms, gardening, and the manufacturing and organisation of various different kinds of materials which can then be rented out;
– supervision and annual work meetings with the local committees;
– the annual organisation of the World Day of Lepers with the National Raoul Follereau Committee to which our Association belongs and which

works in close co-operation with the relevant Ministry, the Ministry for Public Health.

9. The Other African Associations

The presentation of facts which I have just offered to you has been concerned largely with the Raoul Follereau Association of Benin.

In the continent of Africa, where, I would like to observe, our founder began the world-wide battle against leprosy and all other leprosies, there are many associations which bear the name Raoul Follereau, with his message of peace, freedom, brotherhood and love, a message that became an appeal to deal with the acute poverty of the world so that the rights of the poor could be defended and upheld.


RELAZIONE

RENDICONTO DEFINITIVO

I will only speak here about the Raoul Follereau associations of Francophone Africa, which are members, as we are, of the International Association of Raoul Follereau Associations, most of which came into existence long before the Benin Association, which, indeed, is only eleven years old. I am referring here to the Raoul Follereau Associations of Mauritania, Senegal, Mali, Burkina Faso, Nigeria, Guinea Bissau, Guinea Conakry, the Ivory Coast, Togo, the Cameroon, Chad, Congo Brazzaville, and Madagascar.

All these Associations have the same objectives and engage in the same activity but they are not equally successful. The first, such as those of Senegal, Mali, Nigeria, Guinea Conakry, the Ivory Coast, and the Cameroon, were greatly helped at the time of their creation by the French Raoul Follereau Association and by other helpers from the North. But such is no longer the case and today many African associations suffer from a lack of funds and thus from a lack of logistic and organisational means – typewriters, telefaxes, and means of transport (and this is something which greatly diminishes their activity). Perhaps there is a possibility of launching an appeal in favour of these Associations which in the end will run the risk of disappearing if the situation does not change. Indeed, the majority of the populations of these countries are continuing to grow poorer and are developing other forms of leprosy given the selfishness and the stench of money which is to be encountered in these countries.

10. Future Prospects

It can be said that today the African Associations have achieved a secure stage of maturity and a clear idea of the dimensions of the work which has to be done. They will have to go ahead and at the same time increase their field of action and their performance.

If identification, treatment and re-education are engaged in then Hansen's disease will be defeated thanks to polychemiotherapy, an area where Benin has been the most prominent field of implementation. It will be even more important to be concerned from now onwards with the socio-economic re-integration of people who have been cured of leprosy. This is the area of action of the African National Associations whose importance is destined to grow even greater in the future.

These National African Associations have the following characteristics:

– they have the advantage of living amongst and with people in need;

– they have a better knowledge than anyone else of real needs, and engage in constant listening to the local population and its legitimate aspirations;

– they have a greater knowledge of the sensitivity of patients in their relationship with the people who care for and treat them;

– those at the top of these local associations are near to their authorities, both local councils and the national government. They thus have a greater knowledge of politics, strategies for planning, laws, and the requirements and feelings of such authorities;

– they create and foster local committees in their countries and organise teaching seminars *ad hoc.*

They meet absolutely the right requirements to provide help amongst and with the people of their countries.

Founded in the name of Raoul Follereau, these Associations adhere to the Union of Associations and choose a form of adult and responsible partnership. This formula is the only one which works in an effective way for a long-lasting development achieved through help which in the future will no longer need to be long-lasting.

11. Conclusion

In conclusion I would like to say:

it seems that the French revolutionary, Louise Michel, and the great poet, Vicor Hugo, died during the last century after proclaiming that the twentieth century would be a century of peace and happiness. Some judgements of the twentieth century have defined it as being a century of war, barbarity, selfishness and genocide. All in all, evil has prevailed over good.

The twenty-first century which we have just welcomed with faith and fervour will not fail to present individuals and institutions with various challenges.

May the generosity and the nobility of people's hearts prevail over everything and with our Associations may a new spring flower for the victims of leprosy and all leprosies, as Raoul Follereau hoped and wished!

Prof. HENRY VALERE
T. KINIFFO,
President of the Raoul Follereau Association of Benin

Poverty and Health

We have just left a century of remarkable human progress. The health gains of the 20th century count as one of the biggest social transformation of our times. Living conditions have dramatically improved for the large majority of people. But the century also left a legacy. More than a billion people have been left behind in the health revolution.

With vision, realism and commitment, the world could end the first decade of the 21th century with some notable accomplishment. It will take global leadership to set the process in motion, and WHO is ready to play its role – working to the best of its ability, linking up with its partners, linking up with all of you, to unleash a global social movement for health and the role of health in development.

We know the critical role of health in the forging of sustainable development. Health needs trigger economies to grow. We know how important it is to focus on the right interventions. Health systems need to reach all and not only the fortunate few.

We need a shift in our thinking and a shift in the way resources flow. Whereas 90% of the disease burden is in the developing countries, these countries have only got access to 10% of the resources going to health. This cannot change overnight, but it has to change.

What are the challenges?

The basic facts are increasingly well known. About 20% of the world's population, or 1,300 million people, live in absolue poverty with an income of less than US$ 1 per day.

Surviving on less than US$ 2 per day is a reality for almost half the people on the planet. Aggregate figures for economic growth disguise the fact that the number of people in absolue poverty is still rising.

The resulting inequalities in health outcomes are stark. To take some examples: those living in absolute poverty are five times more likely to die before reaching the age of five, and two-and-half times more likely to die between the ages of 15 and 59, than those in higher-income groups. Differences in maternal mortality are even more dramatic: the lifetime risk of dying in pregnancy in parts of sub-Saharan Africa, where almost 50% of the population live in absolute poverty, is one in 12, compared to one in 4,000 in Europe.

Why is better health an important component of poverty reduction?

Ill-health is both a cause and a consequence of poverty. Illness can reduce household savings, lower learning ability, reduce productivity and lead to a diminished quality of life – thus creating or perpetuating poverty. The poor in turn are exposed to greater personal and environmental risks, are less well nourished, have less exposure to information, and are less able to access health care. They are therefore more at risk of illness and disability. As a result, the socio-economic development of many countries is substantially threatened.

The other side of the coin – that better health can prevent or offer a route out of poverty – has been given less attention. Evidence now shows that better health translates into greater, and more equitably distributed, wealth by building human and social capital and increasing productivity. Healthy children are better able to learn, while healthy adult breadwinners are more able to work and provide for their families.

The significance of the findings is clear: ***to move from a vicious to a virtuous*** *cycle, means focusing resources on improving and protecting the health of the poor.* ***The process of globalisation*** *means increasing economic, political and social interdependence as national and global levels are closely interconnected.*

There are many examples of how health already benefits poor people: the campaign to eradicate river blindness, the strategy of directly observed treatment, short-course (DOTS) to combat tubercolosis, implementation of essential drug policies, MDT and early case-finding to fight leprosy – to cite just a few. Since 1985, for example, the prevalence of leprosy has been reduced globally by nearly 85% by curing 10 million leprosy patients.

Over the past decades, the international development community has given top priority to poverty reduction.

Today the overarching goal is to halve the number of people living in absolute poverty by the year 2015. The other three development goals are:

– a two-thirds reduction in under-five mortality rate;

– a three-quarters reduction in maternal mortality;

– reproductive health services for all.

The challenge now for the United Nations is to use its authority and influence to

mobilise the whole international community behind the international targets for poverty eradication. There is now a strong impetus, and an important opportunity, to make health more central to economic and human development, and to provide leadership within the community of organisations committed to improving the health of the poor.

Investing in health development

Today effective medicines and control strategies are available to dramatically reduce ill-health. Yet many governments are failing to ensure that these strategies receive enough funding to succeed. In some cases, this is because health budgets are unrealistically small. In other cases, it is because health spending is poorly prioritised to address the most urgent health threats.

Some of the poorest countries have no more that £27 a head to spend on health care annually – making it difficult to ensure that even the most basic health needs are met. Low-income countries spend 4% of GDP per capita on health, half the amount spent by wealthier countries. In many poor countries, spending is even lower. In Cameron, Indonesia, Nigeria and Sri Lanka, for example, it is less than 2% of their GDP.

Donor assistance has helped supplement underfunded health initiatives. However, resources available for such support are relatively small.

Which health strategies are effective in reducing poverty?

Selecting health strategies to reduce poverty requires a sound understanding of why the poor suffer greater mortality and morbidity. Interventions which rely on the health system for their delivery will be inadequate if the poor do not have access to organised services. Moreover, even if universal access to health services were possible, it is unlikely that this in itself would be sufficient. The reason is that many of the determinants of ill-health, and thus the means for bringing about significant improvements in the health of the poor, will depend on developments beyond the health sector.

An approach is needed which combines investments in health more broadly with better focused investment in health systems.

Just to mention some effective interventions which could prevent the spread of infectious diseases worldwide:

– DOTS (Directly Observed Treatment, Short-course) can prevent 60% of all tuberculosis deaths.

– IMCI (Integrated Management of Childhood Illnesses) can prevent most childhood deaths from pneumonia, diarrhoea, malaria and measles.

– Childhood vaccinations have proven extremely effective in reducing deaths from measles and other preventable diseases.

– Last but not least, one of the most important interventions in interrupting the link between malnutrition and infection is vitamin A supplementation. Routine supplementation in the age range 6 to 72 months can reduce overall mortality by almost 25%).

A health strategy to reduce poverty should include the components described below:

– Acting on the determinants of healths by influencing development policy.

– Reducing risks through a broader approach to publich health.

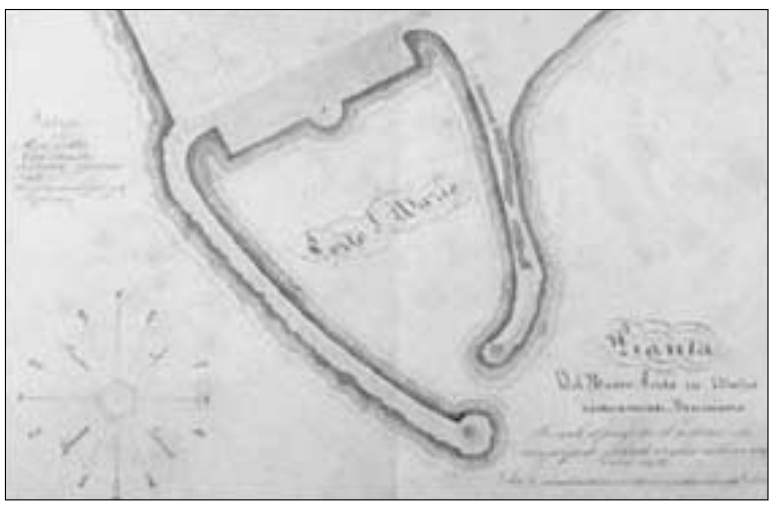
– Focusing on the health problems of the poor.

– Ensuring that health systems serve the poor effectively.

1 - Equitable distribution of the benefits of economic growth is central to reducing poverty. Similarly, it should be our ambition to maximize the health benefits of policy for labour, trade, agriculture, micro-credit, environment and other aspects of development. Success will depend on strenghtening the capacities of Ministries of Health to take the lead in cross-sectoral initiatives.

2 - The challeng facing governments is to improve the access of the poor to basic public health services, including safe and adequate food, clean water, and sanitation. Beyond the traditional domain of public health, however, the poor are more exposed to violence and environmental hazards, and are likely to suffer more during conflict and natural disasters.

3 - A small number of conditions affect the health of the poor disproportionately. Information on the costs and benefits of interventions can also be used to influence the spending of national governments and development agencies. In the first instance, the design of a set of core inter-



ventions would bring together work in such areas as immunization, the integrated management of childhood illness, adult lung health, the integrated management of pregnancy and childbirth, and reproductive health.

4 - Beyond assuring the capacity to deliver essential services, there are several other characteristics of a pro-poor health system. At a minimum, it is one which ensures access irrespective of income, and treats clients with dignity and respect. It protects poor people from unwise practices and financial exploitation in both public and private facilities. It should also protect people who are not already poor from impoverishment due to the high costs associated with major illness. WHO has a role in advising governments on the reforms needed to achieve these objectives. In addition, there are several strategies, for example, the targeting of services, improving outreach, and involving the poor in health care governance, in which the analysis of different experiences across countries would be of particular benefit.

Conclusions

Poverty undermines development. Poverty is an attack on human rights and human dignity. Poverty creates political and social instability. Countries cannot afford massive poverty. The goal of halving the number of poor people by 2015 is achievable. But it will require broad effort from all of us. We have a window of opportunity. It may not remain open for long. The world cannot afford it. Sustainable development for future generations will be a non-starter unless poverty is radically reduced, and poverty eliminated.

Dr. MARIA NEIRA
Director Communicable Diseases Control, Prevention and Eradication, WHO - Geneva

Leprosy: Past, Present and Future

Thank you for inviting me to participate in this International Seminar and to speak about the situation of leprosy in the past, present and future.

I work at the University of Aberdeen which was founded by the Bishop of Aberdeen on the authority of the Bull of Pope Alexander VI in 1495. It was modelled on the Universities of Paris and Bologna and established the first chair of Medicine in the English speaking world.

A historical view of leprosy: The first descriptions of leprosy can be found in ancient India and Egyptian writings. Leprosy spread throughout the world and reached a peak in Europe in the 14th century – then gradually reduced up to the twentieth century.

The cause of leprosy, Mycobacterium leprae, was established by Armeur Hansen in Norway in 1873, but it was not until the 1940s that effective treatment was discovered. Major developments in re-constructive surgery for leprosy took place in the 1950s. In the 1960-70s efforts began to control leprosy in the community using dapsone.

In 1964 resistance to dapsone treatment was first identified and by 1977 dapsone resistance was reported in untreated patients. Multidrug therapy (MDT) was recommended by the World Health Organisation in 1982 to combat the problem of drug resistance. This not only proved successful but the shorter treatment led to a fall in the number of patients registered for treatment.

This fall inspired the World Health Assembly in 1991 to resolve to 'eliminate' leprosy which means to reduce the prevalence of leprosy to less than 1 in 10,000 by 2000 through detecting cases early and MDT treatment.

Present Situation: there has been a 85% reduction in registered cases and over 70 countries have reached the target of reducing the prevalence of leprosy to less than 1 in 10,000. At the beginning of 2000, there still remain about 10 countries which have not reached the target and a commitment has been made to achieve this by 2005. However, does this mean that all the problems of leprosy been solved? Is every patient being detected and treated? Does MDT answer all the needs of those affected by leprosy?

Are there any new cases still occurring? I shall try to provide information about all these aspects. Figure 1 shows the global trend in registered cases (Prevalence) between the period 1985 to 1998.

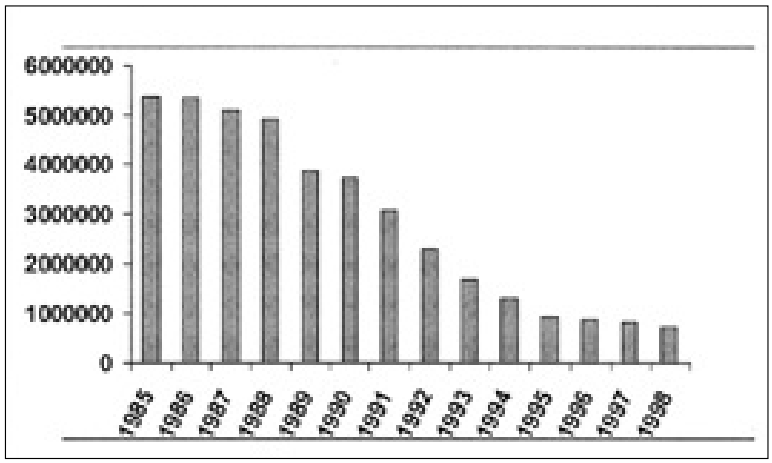
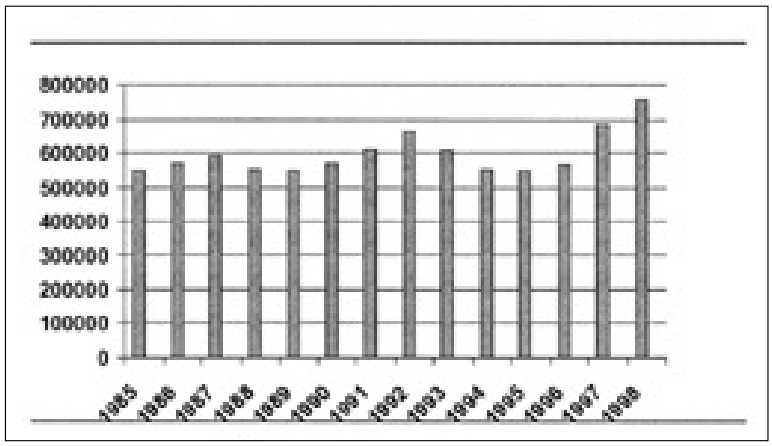


Figure 1

The implementation of MDT world wide has led to a reduction in the numbers of registered cases as seen in this graph. This can be seen in all countries throughout the world. The decline has been by about 85%. However the decline has levelled off in the last four years.

Now let uslook at the trend in the new case detection rates in the same period in figure 2.

Figure 2



The success of MDT and the reduction in registered cases might lead us to expect that the incidence of new cases would be falling too. This graph shows the trend in new cases since 1985. Clearly we see that there is no reduction, indeed the numbers appear to have increased in the last few years. This presents the interesting but confusing pattern – falling prevalence of registered cases of leprosy and constant or increasing incidence in new cases. Why is this happening? What is going on? What is the explanation?

What is happening is that with MDT we are shortening the duration of disease by using short course therapy. MDT is used for 6 or 12 or 24 months, much shorter than dapsone therapy which could be more than 10 years. If duration falls, then prevalence (number of active cases registered at the end of a year) can fall without any change in incidence of new cases.

If we think of complete victory over leprosy, which means disease eradication, that would be aimed at reducing new cases, in reducing the transmission of the disease. It had been hoped that by treating all new cases with MDT the incidence of new cases of leprosy would eventually fall but that has not yet happened.

The global trends in new cases detected covers up important differences between countries. India shows a similar pattern of increase as in the global picture, with a larger increase in the last few years. India represents more than 80% of the global cases and therefore has a great influence on the world picture.

Let us look at the patterns of new case detection in a number of countries. There has been a considerable decrease in new case detection in China – more than 50% in the last 10 years. This contrasts with the global pattern.

In contrast Bangladesh shows a rapidly increasing trend in new cases detected. This would not have been predicted from the changes in prevalence in Bangladesh, which has fallen. This is due to the expansion of leprosy control activities to areas of Bangladesh which were not previously covered.

Brazil shows a very consistent pattern of increasing numbers of cases detected, as seen in Bangladesh. This is a large effect over a short period of time. Again it is due to improvements in the leprosy programme in Brazil and an increase in coverage in the individual States.

The trend in new cases in Colombia shows a downward trend over the same time period.

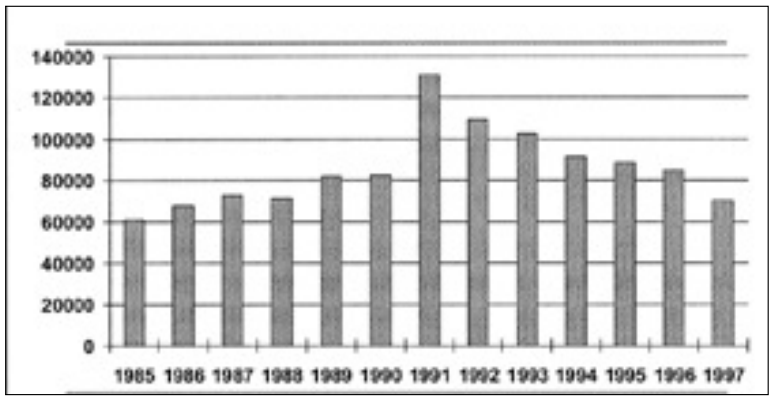
I spoke to the leprosy programme manager in Colombia who described the difficulties for leprosy activities

caused by the civil disruption in that country.

This shows that new case detection is strongly influenced by operational factors and does not necessarily represent true incidence. Case finding methods affected the numbers of new cases detected. Earlier case detection increases the numbers. Improved geographical coverage also results in an increase in new case detection rates. Better information systems and data collection also results in increased new case detection rates.

To have a real picture of the disease transmission, we have to look at some other factors like the number of new cases in children which reflects the risk of disease transmission in a community. Figure 3 shows the trends in new case detection.

Figure 3



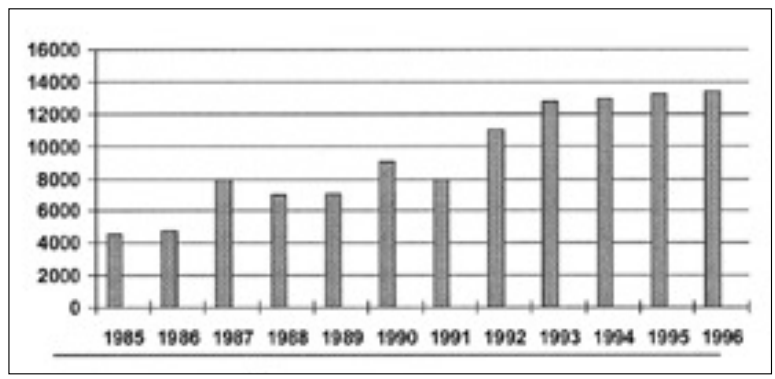
Changes in new cases in children has been considered an indicator of trends in transmission. If transmission of disease stopped then we would see the affect on reduced cases in children. These are difficult to understand as the number of new cases in children increased between 1989 and 1994 while after this period the numbers have gone down but this may be also due to changes in school surveys.

Another fact which may give us an idea about the real situation of new cases is the trends in visible disability in new cases. Globally these data show a downward trend. This means that cases are being detected earlier now than 10 years ago. This would be associated with an increase in the numbers of new cases detected.

We can see this clearly in the data from India – the increase in new cases is matched by a decline in disability in new cases. The increase is therefore likely to be due to better case detection methods in India.

This is not the case if we look at the global data without India. Here we see that the numbers of new cases who are visibly deformed at the time they are first detected is markedly increasing – threefold. The world data hide a large variation between countries which is important to recognise, as shown in figure 4. It shows that in many countries the number of persons with visible disabilities at the time of diagnosis is increasing and this means that case detection activities are delayed.

Figure 4



One of the greatest achievements of the past decade is that over 10 million patients have successfully completed MDT. However most of these people are still alive and several million of these have impairments and disabilities.

Future Priorities: this leads us directly into the important questions of the future priorities in leprosy. There are three obvious issues which directly arise from the present situation:

– The continuing occurrence of new cases means that the first priority is the need for these cases to be detected early and treated effectively to cure leprosy and prevent disability. If we fail to do this then the prevalence of leprosy will start to increase and all that has been achieved will be lost. The importance and the scale of this must not be underestimated – it requires the availability of MDT drugs, and the efforts of health care staff reaching hard to reach people, and the participation of their communities.

– Leprosy is a disease which has physical, social and economic consequences for those affected. So rehabilitation is the second priority.

– The third priority is research.

Research in leprosy had reduced in the last 10 years but in the last few years the importance and relevance of new research has been appreciated. The Genome Project, sequencing the genetic material of mycobacterium leprae will be completed at the end of January 2000 – this is already opening up new potential for research.

In the past few years research into nerve damage in leprosy has improved our understanding of this and there is the prospect of preventing nerve damage in leprosy. Finding ways of preventing

transmission of leprosy is a critical research priority. New research methods are being developed and vaccine and chemoprophylaxis options are being studied.

We need to understand the factors which can influence the transmission of leprosy incidence. There are 3 groups of factors which influence transmission of leprosy:

– Agent factors – mycobacterium leprae.

– Environmental factors.

– Host factors – people.

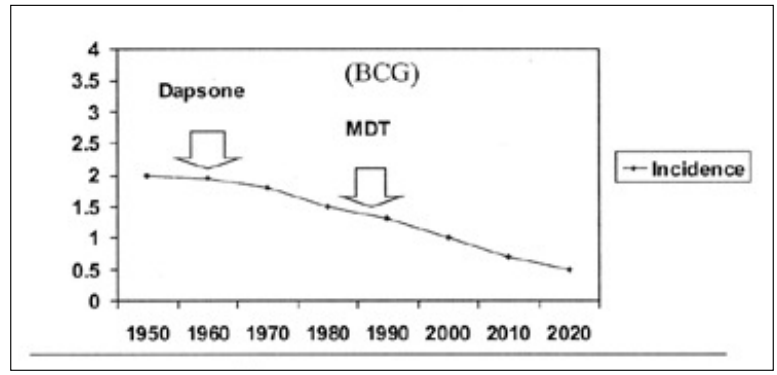
There are many environmental factors which can influence the incidence of leprosy. Socio-economic development is linked to falls in leprosy as we have seen in many countries. These may be the factors which led to the disappearance of leprosy from Europe. Some believe there may be environmental reservoirs of leprosy but there is little evidence for this.

There are also host factors which influence the incidence of leprosy like: immunity such as vaccines or infections with other mycobacteria; susceptibility – so far HIV-AIDS has not been shown to be a major factor; exposure to leprosy bacilli in households and other contacts. Drug treatment is another factor which may influence the incidence of leprosy.

Others factors include drug resistance and relapse rates and the survival time of the organism outside the human host. So far there is little evidence that these are important problems.

If we continue with MDT treatment, when can we hope for victory against leprosy?: The following figure (Figure 5) shows that it may need up to 20 years to have significant decrease in new case detection rates of leprosy.

Figure 5



This graph is based on the SIMLEP disease model produced by colleagues in Rotterdam. It uses existing understanding of leprosy and predicts a gradual effect of drug therapy and BCG vaccine in reducing the incidence of leprosy over a long period of time. Research is needed into ways of increasing the fall in transmission and the incidence of new cases.

The three important principles for leprosy work in the future are:

1. Sustainability – new cases of leprosy are continuing and many of the consequences are lifelong so our approaches need to be sustainable.

2. The leprosy workers cannot do everything themselves – they need to work in alliances at all levels with other agencies, other health care workers, social services, communities, patients themselves and their families.

3. Anti-leprosy services need to be integrated with general health and social services – this includes training, primary health care, hospital care, and community based rehabilitation.

To summarise this presentation:

1. The PAST has been characterised by caring for those affected by leprosy without any effective treatment.

2. The PRESENT era has seen the development of highly effective treatment for leprosy and millions of patients successfully treated. This has led to the dramatic reduction in the prevalence of registered cases but so far no reduction in new cases at a global level.

3. The priorities for the FUTURE are: that all new cases of leprosy are detected early and treated properly; the physical, social and economic rehabilitation of those affected by the consequences; and research into reducing transmission of leprosy and the prevention of nerve damage.

Prof. CAIRN SMITH
President of the ILEP Medico-Social Commission, University of Aberdeen, UK

The Creation of the ILEP

In order to understand how the movement created by Raoul Follerau is organised it is necessary to engage in a little history.

Raoul Follereau was a born orator, one of the greatest of the century. He placed his immense talent at the service of the causes he held dear. First and foremost for the 'defence of Christian civilisation against all forms of paganism', then for am exaltation of the memory of Rev. Charles de Foucauld, and finally to know 'what the world owes France' through a famous conference given thousands of times before, during, and after the war in France and various other countries of Europe. All the men of my generation listened to this conference and it was in listening to it at the age of sixteen in 1941 that I discovered Raoul Follereau.

A meeting with the female religious of Our Lord of the Apostles led him to abandon his political-religious struggle and to dedicate himself to charitable action. It is certainly the case that until his final breath he remained loyal to the ideals of his youth but from 1942 he placed his talents at the service of lepers who were for him the most suffering and oppressed minority that existed.

During the whole of the 1940s he fought alone. Then during the 1950s, given the success of his conferences, he asked his friends to create local committees, entities which are called 'gruppi' in Italian. In the 1960s he asked us to create national and international structures which could respond to the dimensions which his work had taken on.

In 1956, during an audience, His Holiness Pius XII supported him in his project of bringing together within a single federation all the associations which were fighting against leprosy in the world.

Pierre Van den Wijngaert, the Belgian polyglot who had just created the 'Friends of P.Damien' in Belgium, had the idea of organising an encounter on the subject of 'the common market of leprosy'. He went to meet Raoul Follereau and explained his project to him. Raoul Follereau, listening to him, had the impression that he had finally found the man who could implement his project – the joining together of the forces of leprosy at an international level.

Raoul Follereau, who knew Pierre well and trusted him, agreed to preside over this encounter and to direct the debate. In this way, in Brussels on 2 October 1965, there took place the first European meeting of the associations engaged in the struggle against leprosy and it provoked such a level of enthusiasm amongst the associations which were there that it was immediately decided to create a European body to struggle against leprosy and to elect a committee to prepare the ground for the formation of such a body.

This is why on 25 September 1966 there was held at Bern, under the presidency of Marcel Faine (President of Aide aux Lépreux Emmaus-Suisse), the first general assembly of the European Federation of the Fight Against Leprosy (ELEP). Its essential aim was the following: *to co-ordinate the action of its members so as to avoid overlapping, competition and demagoguery.*

Pierre Van den Wijngaert made these comments on the goal which we had set ourselves: 'although the raising of funds is a difficult task, their intelligent distribution involves even more serious responsibilities'.

But it was not easy to make the associations collaborate, because although they had the same task they were in fact very different: some were many centuries old (such as the Order of Malta), others had an established religious character (such as the Leprosy Mission of London), and others were national associations marked by the character of their own countries (such as the powerful DAHW of Wurzburg, Redda Barnen in Switzerland, FOPERDA in Belgium, or the Leonard Wood Memorial in the United States of America), and others had responded to the appeal of Raoul Follereau (such as the associations of England, Belgium, France, Italy and Luxembourg).

In those years (thirty years have since passed by) there was a great deal of talk about the construction of Europe. We wanted to construct the Europe of leprosy. In order to succeed we sought to know each other. This was not easy because we had fought a war against each other and with each other. We wanted to overcome all of that in order to help build a society which was based upon love.

This is what Raoul expressed in his message to the VIII general assembly of the ELEP held in Rome in 1973: "beyond all the national, political or spiritual barriers, without vanity, without ambition, with a perfect selflessness, you remain at the service of those of whom you are the benefactors, the protectors, but above all the friends".

In the spring of 1975 the European Federation of the Associations against Leprosy (ELEP) ceased to be European and became international with the entrance of an American member, the American Leprosy Mission, and a Japanese association, the Sasakawa Fund.

What we achieved in the ILEP was exemplary. Seen from the outside as the Paris Club of Leprosy (that is to say as its financial backers) the members of the ILEP have been the only people to finance the struggle against this disease over the last forty years. The success achieved in the struggle against leprosy over the last decades is thus something which should be attributed to us.

This has meant, every year, 1,190 projects financed by the member associations of the

Federation for a total sum of about seventy million dollars. Thus it was that from the beginning in order to heal millions of lepers almost two milliard dollars has been collected from generous people from the countries of the North of the planet for their unfortunate

brothers living in the South. One of the principal aims of the ELEP was that of organising a chain of solidarity between those who had and those who had nothing. We are, however, far from being mere financial backers – we are partners and as such we want to operate on a footing of equality with the States that we help and with the World Health Organisation.

The co-ordination of our activities is the only way by which to avoid competition between the associations and overlapping with regard to those who receive. I remember that at the moment of the creation of the ELEP a nurse who had helped our initiatives wrote to us all about the same thing: 'I have thirty-two lepers to take care of and feed and nobody is helping me'. Each one of us acted on our own without consulting the others and this able nurse thereby received the sum of thirty-six million francs.

I well know that those who receive are wounded in their dignity and I understand them. But in order to be effective, in order to be just, in order to be generous, charity, which is essentially a question of the heart, must nonetheless be organised with specialists and professional people.

If the organisation of the battle against leprosy has been conducted in an exemplary way, the principal credit for this must go the idea of Raoul Follereau and Pierre Van den Wujngaert, who established the International Federation of Associations against Leprosy, whose chief aim was to co-ordinate the activities of its members.

This seems so simple when writing that one asks oneself why it was necessary to create an organisation for something so elementary as the co-ordination of the activity of associations which fight for the same goal. Co-ordination assumes, on the part of the associations which accept it, not a subordination to the agent which exercises it but a leadership which is freely accepted and naturally received.

The agent which exercises it must provide proof of competence and knowledge of the terrain and of men. In this way it is possible to avoid the forms of competition which arise from a rivalry which is no longer healthy emulation but something which compromises the drawing up and the development of programmes and involves expenditure which can create problems with the countries concerned.

One can thus better understood the positive step of Raoul Follereau and Pierre Van den Wijngaert in creating a European federation. It is true that at the time when the European institutions were created a desire to draw near to each other existed within all the European peoples. Those who took part in the creation of all these institutions well knew that this drawing near would have involved a certain loss of freedom but they unanimously believed that this was a modest price to pay in order to avoid a return of conflict.

The associations which bear the name and follow the work of Raoul Follereau thus have an important role to play today in the world in order to ensure that the kingdom of love triumphs, that is to say mutual understanding, the forgiveness of offences, mutual tolerance, so that *intolerance* ceases, something which is perhaps the greatest leprosy of our time.

I hope and wish to the full that the ILEP achieves the goal for which it was created. I hope and wish that its members never forget that they owe the victory they are about to achieve over leprosy to the co-ordination of their activity, and I hope and wish that at the time when this success leads them to other struggles they will employ the same spirit of co-ordination in these new fights against other forms of leprosy.

In the message which I have already cited Raoul Follereau told us in 1973: "perhaps one day you will be called upon to extend your struggle against other forms of leprosy! It seems that by now you need to prepare yourselves for this... Remember doing good does not mean imposing good... but... very simply and humbly offering oneself..."

In his message of 1974 to the general assembly held in Bern he added: "don't allow yourselves to be hypnotised, that is to say anaesthetised, by the figures of our budgets. The considerable sums which you distribute are essential, certainly, to carrying out and winning the Battle against Leprosy. But their sole and impressive value is that of being made up of an almost infinite number of actions of love carried out by poor, humble and at times sublime hearts which have drawn from the necessary, that is to say from the indispensable, because a smile illuminates, in the heart of the savannah, faces which they will never see".

The following year, in 1975, he gave us his last message in Bonn: "this very happy development should not make the beating of your hearts less perceptible... or involve emulation giving way some day to rivalry... Everything that is achieved without ideals is destined to failure... Our real strength, our secret weapon, is our friendship..."

May this friendship amongst the members of the ILEP last for ever! I hope and wish this with all my heart.

ANDRÉ RECIPON,
President of the 'Raoul Follereau Group', Paris.

Raoul Follereau: An Extraordinary Witness of the Twentieth Century, A Look of Love Towards Others

'I have tried during my life as a man, with the strength of a man, with the instruments of a man, to put into practice what I wanted to bring about'.

The Wanderer of Charity made this lapidary observation at the end of his life.

I would to thank very warmly our friends of the AIFO who at the beginning of the new millennium have wanted to remember in this hall one of the most important voices to characterise the twentieth century.

The organiser did me the honour to entrust me with this difficult if not impossible task. How can I communicate to you in the short time which is available to me the innumerable and fruitful experiences of the life of Follereau, and how can I make you grasp the vigour of the thought of this effective idealist whose entire life, indeed, was one single battle against human misery?

However, this undertaking is a cherished duty for me because I believe that it was an honour for my life to win the favours of his esteem and his friendship, to work for eleven years at the side of this great Christian humanist, this visionary, the singer of love and charity, and the tireless defender of the rights of man, which for him were, above all else, the rights of poor people.

Who was Raoul Follereau?

I believe that I met a saint of modern times.

Not a saint who fled into the white zones of metaphysics, not a figure of glass, but a saint in blood and bones, devoted to other people with a rare passion which lived within him and devoured him. A giving of all of himself, like that of Christ on the path to Golgotha.

Follereau loved those he was speaking to with his body, he touched their shoulders, he took them by the arm, shook them, pressed them, often all at once.

And he became for history 'the man who took lepers in his arms'.

Eating with them, drinking with them, were for him acts of communion, like those of the Last Supper.

Pierre Fresnay, a member of the Comédie Française, said of him: 'this man unleashes such a warmth that on touching him you feel better'.

Raoul Follereau was born on 17 August 1903 in Nevers to a family of industrialists.

The framework of my paper does not allow me to outline the history of his life. For this reason I will confine myself to a short biography.

History will remember him as one of the most extraordinary witnesses of the twentieth century.

In 1943

Hiding with the Sisters of Our Lord of the Apostles he began his battle against leprosy by planning the construction of a centre for lepers in Adzopé in the Ivory Coast. *This was his first step, which was spectacular and tenacious, to free the lepers from the forms of ostracism and injustice which had always been imposed on them.* He would dedicate ten years of his life to the realisation of this project.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In 1954

He created the 'World Day of Lepers'. This would be his most spectacular action in the sense that since its creation its success has grown and grown, and today this day is celebrated in 152 countries.

In 1952

He asked the United Nations for a kind of international convention for the defence and dignity of lepers. This action would have a follow-up.

In 1959

The medical congress of Tokyo recognised that he had achieved a new chapter in leprology – sociology. His famous letters to Roosevelt, Eisenhower, Kruschev, U. Thant and many others form a part of history. He was the man whom young people saw as a guide and example. Three million young people responded to his initiative in favour of 'a day of war for peace' and sent letters to the United Nations supporting his appeal.

In 1966

He was to be found in Berne amongst those who in 1966 founded the ILEP, which today is the world co-ordinating body for the fight against leprosy and whose honorary life-president he would later become.

In 1967

I had the pleasure of organ-

ising his visit, and accompanying him, to our Minister for Foreign Affairs, M.Gaston Thorn, who was then President of the United Nations. I was able to bear witness to the ease and conviction he displayed when he spoke in favour of the adoption of the Universal Declaration on those Sick with Leprosy, the logical sequel to the request of 1952 which had remained a dead letter.

In 1971

The Constituent General Assembly of the International Raoul Follereau Foundations. The first President of this body was André Recipon.

A compelling orator, a poet of adventure, a journalist, a reporter, a dramatic author, he used words, and modern means of communication, in order to conduct his battle against leprosy and all leprosies.

4,000 conferences, 44 books and pamphlets, round the world thirty times, frontiers crossed thousands of times to hunt out leprosy wherever it was to be found and to combat selfishness, that more powerful leprosy.

Lastly, the publication of the 'Book of Love' – a condensed version of the thought of Raoul Follereau – the fruit of fifty years of reflection and work at the service of the poor. This work was printed in eight million copies during his lifetime and was translated into thirty-four languages.

In 1977, 6 December

The apostle of lepers left us for another world.

We are ready to receive these historical facts but it may happen that the essential character of his message will really elude us:

Follereau – a madman who thought he was Follereau?

Or,

Raoul Follereau – one of the most extraordinary witnesses of our epoch?

There are movements which can be explained only through the person who gave the initial impetus to them and which can be understood only through a figure of great force. Raoul Follereau was such a person.

In a world shaken by violence, in this reverse Adzopé, where man feels that he is without warmth, and despite the disappointments, Raoul Follereau created a lineage of generosity and culture.

From 1942 onwards Raoul Follereau, the writer, the philosopher, the journalist-reporter, the man of adventure, the nonconformist, became the man who understood that the scourge of leprosy not only condemns man to a slow and terrible death but also afflicts him with cruel, unjust and scandalous ostracism. This leprosy which gave rise to so much fear was nonetheless a disease like any other after Dr. Armauer Hansen had discovered the leprae microbacterium. Men and women of extraordinary courage – amongst whom the leading figure was Padre Damien de Veuster (the patron of our Belgian friends) – fought tirelessly against this disease. But who in actual fact knows their efforts, their heroism?

In the opinion of Raoul Follereau it was necessary to apply a whip lash to scientific research, to those at the head of the state. And to achieve this it was necessary to mobilise public opinion and place in contemporary eyes this scourge which had been known about since ancient times. He placed the modern means of communication to work.

Together with his wife he went round the world thirty-two times in order to discover his sick people in the most forgotten corners of the world of the poor, and thus he was in permanent contact with the physical decomposition of an abandoned minority. In descending into the abysses of human misery he measured their real scale.

He shouted his truth into the face of the world which was increasingly insolent in its denials.

In these abysses of human misery, in these leper colonies as they once existed, Raoul found his chosen people. And it was this chosen people of

the disinherited who made him a Wanderer of Charity. As a man of action he communicated and drew out a whole pacific army from his experience. His horror of conformity meant that he was openly scandalised, that he did not accept the cruel condition of the leper, and that he did not want to be at one with abandonment.

This personal experience was not a fine theory conceived in an empty white space but a location for engaging in direct contact with evil, with misfortune, and the wicked behaviour of man.

This contact with decomposition made him understand that leprosy *is within us as it is within them.* Leprosy attacks everybody, some visibly, others invisibly. At first glance it is not noticed but deformations exist. Yes: it is too often the case that our hearts, our characters, our spirits and our souls are in decomposition. And God does not love putrefaction. God does not accept the cowardice of declaring that the causes of our repugnance are incurable and the effects of our laziness are irremediable. In His eyes our obstinate rejection alone is incurable after we have engaged in the implementation of our best efforts.

TO LOVE – TO SAVE:

these were the key words of Raoul Follereau.

Through his front-line experience, physical contact with the cruellest kind of misery, he established the right counter-weight to this SUFFERING. TO LOVE – TO SAVE. And from these beliefs

was derived his axiom which sprung from his heart like a wave which presses upon an over-full vase.

'The only truth is that of loving – Nobody has the right to be happy alone!'

In this way Raoul Follereau, through his experiences of fighting against leprosy, followed a path which would give him access 'to all other leprosies': hunger, miserable dwelling places, despotism, the madness of insensate armaments, all the exclusions of our time: drugs, the tyranny of a lack of work, and finally those hard-skinned leprosies – selfishness, scandalous riches and insulting contempt, and visible and invisible forms of injustice. On the contrary, it enabled him to discover with others all forms of exclusion and injustice. His message became richer from that moment onwards endowed as it was with a vaster dimension.

Those who carefully study the thought of Raoul Follereau, as expressed in his work 'The Betrayal of Intelligence', can observe in the work of his life the presence of a *constant struggle against every supremacy of negation.* He fought against all those spiritual forces which degrade man and which destroy his deep order and eliminate authentic human happiness. For this reason, Raoul Follereau was in reality concerned with *all forms* of leprosy.

This at the time was a constant theme of the philosophers Bergson and Raissa and Jacques Maritain. It was his answer to the philosophers of positivism which at the time became the religion of the intelligentsia.

Was not the real fight of Follereau a burning desire, a ferocious wish to save in man that which makes him a man? An ethical approach which we can trace back to the following formula: absolute respect for human life. For Follereau human beings were all equal in dignity from their conception until their natural death, an equality in dignity which did not mean dignity.

Follereau with lepers and the excluded.

Damien de Vuester with lepers.

Mother Teresa with the dying of Calcutta.

Abbot Pierre with the homeless.

P.Tritz with children of the street.

Jean Vanier with handicapped children.

Frédéric Ozanam with the poor.

Sister Emmanuelle with rag sellers.

The look is the same.

It is a look of love directed towards others.

If Descartes was able to affirm in his famous phrase 'I think therefore I am', I am certain that Follereau defended his own truth with equal conviction: 'I love therefore I am'. Here is to be found his criterion of truth.

The philosophical idealism of Descartes *REDUCED* man to a disembodied thought; Marxism often reduced him to a sum of economic relations; Freudianism reduced him to a cluster of passions, and Sartre reduced him to freedom without reference to ideal values. Structuralism reduces him to a mere toy in the hands of impersonal systems.

This 'I love therefore I am' allowed him to make man appear a subject, a 'me', an active and irreducible centre of initiatives, the end and not an instrument at the centre of things and forms of modern technology which threaten to devour him, to annihilate him, and to relegate him to a mere secondary level.

Follereau deduced this philosophy from his relationship with God.

In his relationship with *God* we find the three key words of his faith and his thought: 'God is love'. He uttered this phrase at the age of fifteen and finished his life with the certainty that 'God is our ULTIMATE FRIEND'.

God is love: Raoul Follereau deduced this truth from the EIGHT WORDS which Jesus of Nazareth pronounced on the slopes of a mountain in the month of June of the year 28, words which marked the page of the great book of the world. Indeed, the text of the Sermon on the Mount would be the most important of the New Testament because it was directed towards believers and those who do not believe, and would be according to the Hindu, Ghandi, twenty centuries later, the only light to shine in the shadows of violence, fear, and loneliness in which pride and selfishness have immersed us.

Raoul Follereau had the faith of a coal seller. He was a positive man.

These eight words were for Raoul Follereau the Code of the New Covenant between God and men. For Follereau the Gospels were the inner expression of Christianity and the Beatitudes were the summary of the meaning of the Gospels. For Follereau, a positive man, these decisive eight words were all positive. He read in them the opposite of the Crusades, the Inquisition, and anathemas.

It is easy for me to imagine Raoul Follereau amongst the crowd which surrounded Jesus on those slopes twenty-five leagues to the north of Jerusalem which go down to the lake of Genazaret in a tranquil countryside WHERE THE THUNDER SOUNDED EIGHT TIMES. Follereau felt that the essential had been said and that the great PROVOCATION had begun. This is the way I want to discover him reading the Gospel. He realised at a stroke that for two thousand years humanity had possessed the key to truth and had left it in the bottom of its

pocket. Everything that that provoker dressed in white who came down towards the lake of Genazaret as twilight fell said had already been felt by Raoul Follereau within himself.

For him Christianity was a *'brotherhood on a journey'*.

'We should love poor people, happy people, love strangers, love our neighbour who is at the top of the world, love the foreigner who is near to us, love...without love there are no genuflections, bells or Lents which resist over time; if you do not love you are not Christians'.

We do not have time to speak about his social beliefs and real charity. For him, the sharing of the wealth of this world in a fair way was something which meant taking part in the creation of God.

It is, however, important to analyse the richness and wealth of the thought of Follereau in order in a few words to look at the relationship which *linked* Raoul Follereau to *his young people.*

This was a relationship of trust. Young people do not like people who wear masks. Follereau fought with an uncovered face; he did not dissimulate, and did not betray. He accepted this relationship as though he was one of them.

'After fifty years I am still twenty years old' he said without any fear of being in error on his seventieth birthday. Who could say such a thing in front of young people without appearing ridiculous? He could do it because he could attest through the work of his life to the authenticity of what he preached to young people.

He made young people 'the universal heir of his work' and invited them to say 'no' to the suicide of humanity faced with the Great who continued their monstruous armaments industry. The treasure which Raoul Follereau left to them is the good which he did, which he wanted to do to young people, of the Right, the Centre, and the Left, those who have received the gift of the faith and those who act as though they believe, those that believe and those that do not believe.

And because they trusted him he had the right to warn them through his famous ten 'Appeals to Young People'.

Raoul sought to understand their bewilderment, something characteristic of them and the century. The most serious fact, in the opinion of Follereau, was that young people had been put in a world in which an attempt had been made to eliminate the existence of God. For them a civilisation had been created of disgust and desperation. Nothing before life, nothing after. What, then, is the point of life?

He warned them about 'not becoming prey to the snares of intelligence which leads them along roads without flowers which in turn brings them to nothing'.

He warned them about drugs and accused the world of adults which closed its eyes, and condemned 'this civilisation of waste, incapable of freeing itself from its own residues'.

Faced with a drugged youth which had killed itself he spoke about the *murdered child* of his century and rebuked society: 'behind the murdered child is the dark cohort of those who have deserted'.

He understood the void which provoked dizziness in young people and which expressed itself in rejection and violence. However, Raoul Follereau, a positive man, a philosopher of hope, invited adults, the witnesses to the putrefaction of the twentieth century, and young people, to build a city on a human scale so as to serve the human being without oppressing him, to build an open Christian city, disinfected of its superstitions, of its testimony, and of its forms of cowardice: a loyal life with God.

He wrote that we see young people return to a theology of renewed love. Often in troubled, indignant, hearts the naked Christ has found refuge and faith has flowered, and this is a virgin faith.

Rejecting the way of practising constantly re-cooked religion, entrusted with ensuring that we avoid the hard blows of the other world, and anxious, above all else, to calm in this world the small fears which render us stupid, young people committed themselves to serve a Christianity which does not worry whether the glass of water is repaid or otherwise, of a Christianity which does not search to manoeuvre God, and of a constructive and conquering Christianity.

They served it in an attic, a garage, and a factory as much as in a mobile clinic.

'Ozanam is always twenty years old'.

'To live means to help to live. To be happy means to make other people happy'.

Such were the words of Raoul Follereau on 7 November 1976 when he attended for the last time a meeting of the associations which bear his name. I quote:

"In this way the 'Battle against Leprosy' bears witness, first of all and above all else, to the supremacy of love. Remain faithful to it. The man who receives is helped. But it is he who gives who is enriched.

Leprosy, which for millions of men has been a martyrdom and a curse, should, in a future which I believe very near, cease to be an exceptional evil.

Leprosy will cease to be revenge. But the battle which has defeated it will always be an example and witness: 'without love nothing is possible. With love nothing is impossible'.

This success should encourage us to struggle, tomorrow, against other evils and wickedness, against other forms of degeneration.

With the same dynamism and equal fervour continue your battle against all the forms of leprosy of which, as I have often repeated, this is only a chapter in a united whole".

Dear Father Raoul, may God hear you!

From on high in heaven may you continue to beseech your brothers and sisters of the ILEP to remain united in order to meet other challenges!

JOS HILGER,
President of the Raoul Follereau Foundation of Luxembourg.

The Figure of Padre Damien

The Damien Foundation 'Association for the Fight Against Leprosy' always refers back to Padre Damien, as is borne out by our statutes and as is demonstrated by the reality of our actions. Our most recent day of promotion, which took place in November 1999, declared: 'with Damien we will enter the year 2000'.

With regard to the statutes we should mention article 4 which says: 'the Association has the aim, following the example of Padre Damien and basing itself on his work, to contribute to the fight against leprosy in the world and other medical-social problems through action at different levels...'

'The Association encourages equally all the forms of activity directed towards information and the raising of the awareness of the Belgian population...'

'It follows these goals and aims in all independence and free from every consideration of a political, religious and racial character'.

It is known that a certain number of countries turn to us in an increasing way in order to control tuberculosis, among other things. The present-day objectives of the Foundation are therefore those of 'taking part in the uprooting of leprosy and the control of tuberculosis', and this is something which involves a very fruitful energy. But leprosy remains the principal concern of the Foundation because it has not yet been weakened and many years will still be required for this disease, and its consequences, to be completely eliminated from the face of the earth.[1]

In the year 2000 we will begin a new intensive campaign to identify the presence of leprosy in Bihar, a state in the north of India where 25% of all the cases of leprosy in the world are to be found and where we identified and subjected to treatment about 120,000 new cases in 1998.

In order to understand what the figure of Padre Damien represents in the world, in Belgium, and for the Damien Foundation, we should bring to mind the life of this Belgian priest who dedicated himself to the lepers of Molokai, one of the islands of Hawaii, from 1873 to 1889, the date of his death, which took place after many years of suffering caused by being infected by the bacillus of leprosy itself.

A large number of biographies have been dedicated to Damien, whose heroic actions were already known throughout the world when he was still alive thanks in particular to writers in the English language. One should however give pride of place to the monumental work of Hilde Eynikel which is a revised and much re-written version of the first edition published in Holland in 1993.[2] We now have a set of data which enable us to place the history of Damien in a variety of contexts, and map all the stages of his life, in particular during his apostolate in Molokai. The work is introduced in the following terms: 'After staying for seven visits in Hawaii and the island of Molokai in order to explore all the places in which Damien lived from 1863 to 1889, and in order to look through the local civil and religious archives, Hilde Eynikel was in addition the first person to gain access without limitations to the archives of the congregation of the Fathers of Picpus, the order to which Damien belonged, in Lovanio'.

'This biography is the result of an unprecedented investigation. There emerges a figure of truth of exceptional breadth which because of its universal dimensions reaches those of a Gandhi or a Mother Teresa of our age'.

'Damien appears not only as a heroic missionary but also as a fighter in conflict with the hierarchy, a pioneer in the medical-social field because of his struggle against exclusion and his pain-reducing approach to incurable illnesses; and at a religious level as a pioneer of ecumenicalism'.

The world of the nineteenth century was very different from today's world. The Belgium of that period was very different from the Belgium of today. And lastly, and above all else, leprosy presented problems and challenges which are no longer known to us.

Padre Damien was born on 3 January 1849 with the name of Joseph De Veuster, and as a religious he would become 'Padre Damien'. He was born to a family, a region, and a country in which the Catholic tradition was very deeply rooted. It was therefore almost normal for the young Joseph to have thought of the priesthood and to have engaged in studies to fulfil his vocation. At the age of seventeen he entered the congregation of the Fathers of Picpus who were still called the Fathers of the Sacred Hearts. He took this opportunity to leave as a missionary for the Hawaii islands before being ordained as a priest. He said adieu to his parents, which at that time was a real adieu, and embarked on a ship which brought him within five months from Bremehven to Honolulu, the capital of the Hawaii islands, travelling via Cape Horn.

From 1864 to 1873 Padre Damien engaged in a classic apostolate but one which was marked by a no means ordinary dynamism. In the immense regions which were entrusted to his care he constantly went around on horseback in order to keep in contact with all his faithful, perform baptisms, maintain or build places of worship, etc.

During the course of those years the authorities of the Hawaii islands, which at that time made up a kingdom, raised the question of how the

lepers should be treated. Their numbers were increasing, an epidemic was underway, and a general contagion was feared. The Health Council of the islands acquired a territory on the peninsula on the north of one of the islands called Molokai – a rocky outcrop of 600 metres high on one side, and a rough sea on the other three. The lepers were deported to this place compulsorily and confined to this narrow space.

From 1873 to 1889 Damien passed sixteen years in this place amongst the lepers. The superior of the missionaries had asked for volunteer priests for Molokai and Damien had accepted immediately. He left for the leper colony, he became bound to them, and finally he decided never to leave them.

In all those years he acted with the dynamism, the force and the independence of action which were his great qualities. For him it was a matter of a continuation of his activities as a missionary and, for example, of presenting Jesus to his parishioners as 'the physician of the body and the soul, the companion'. In 1874 he drew up his first balance of what he had achieved – one church, 116 baptisms, 30 funerals, and 10 marriages.[3]

But he did not confine himself to taking care of souls. Given that he had before him very painful situations, from both a physical and a moral point of view, he sought to improve the conditions of the lepers. He thus concerned himself with their housing, food, and medical treatment. For example, he was very interested in the various forms of treatment and himself acted in this sphere without stopping even to the point of performing amputations. At the price of tireless work, and without forgetting his own obligations of prayer and evangelisation which today make up a large part of his programme, he gave a new impetus to this centre for lepers.

For hundreds of lepers who were under his protection – from 580 to 1166 in number according to an official report – he often became a 'doctor, nurse, organiser, carpenter, gardener, and undertaker'.[5] There has often – inevitably? – been emphasis in an excessive way on the multifaceted character and the exceptional qualities of this action. To believe a number of texts and cartoons – yes: Padre Damien exists in cartoons – Damien himself built a large number of coffins, something, however, which has not been corroborated. With regard to this fine story, we should without doubt prefer to keep close to historical truth.

Damien knew perfectly that he on his own was not up to the task and for this reason he asked for help on more than one occasion from 1873 onwards – female religious, missionaries, medical doctors, and lay support finally arrived in the end. Various people carried on his work when leprosy claimed him as well in 1889.

Padre Damien lived amongst the lepers and did not refuse contact with them in any form. He contracted the disease it would appear during the first years of his stay in Molokai. The diagnosis was carried out in 1884 and from that moment onwards the famous phrase used by him 'we lepers' acquired full meaning in that place and in the world.

The action of Father Damien was always noticed and attracted some suspicion and some jealousy, in particular on the part of the Protestants, but it also provoked admiration and help, especially on the part of such Protestants as Rev. Chapman of London.[5]

Padre Damien was famous during his life, a fame he had never sought, and after a century he is increasingly famous. Indeed, he was beatified in 1994. It was observed that in the 'thick' forest of the 'heroes of charity' 'we know above all else the giant trees... the illustrious Padre Damien'.[6] Many others, in reality, have lived with lepers and some of them died from leprosy, like Padre Damien himself.

The figure of Padre Damien has been the object of special regard, especially in Belgium. The return of his remains to that country in 1936 was a national event. A large number of articles and books have been devoted to him. His beatification in a certain way began a new era which Cardinal Danneels characterised as follows: 'Brothers and sisters for a long time we have admired Padre Damien as a hero. The moment has come to pray to him as a saint'.[7]

With regard to the Damien Foundation the example given by him has often been remembered in numerous articles and publications. The image of Padre Damien often appears in our texts and it always returns us to the reality of exceptional action which the Foundation seeks to translate into modern terms but with the same dedication, the same force, and the same realism.

Lastly, mention should be made of the film by Paul Cox 'Padre Damien' which has been shown on the screens of Belgium and which is continuing its career in the world. Filmed on location in Molokai with the help of H.Eynikel, in realistic fashion it narrates the principal aspects of the activity of Damien and helps to make him better known and better understood.

As was agreed, I have limited my paper to the figure of Padre Damien. But our Foundation willingly also remembers the great figure of the Belgian doctor, Hemerijckx, who took care of lepers in the Congo and in India, and of course the great figure of Raoul Follereau. Finally, and in order to guide possible reflection, I would like to quote from two classic texts:

– the first is from J.Leclerq's 'Saints of Belgium': 'the saints of Belgium are the best amongst us, but they are

amongst us, and if they do not have the defects of many of us, they have certain failings'. 'To express this in a word, they lack greatness. Holiness requires virtue pushed to the point of heroism. No people gives people who are more honest and admirable but we are rebels against magnificence. And these are moral forms of magnificence'.[8] The whole of the last chapter of the book, entitled 'the debate about holiness', develops this idea, dwelling upon a certain number of our saints. It is right to think that the prestige of Damien is to be found precisely in this magnificence to which he bore testimony in Molokai;

– and in his 'Letter to the English' G.Bernanos writes: 'the cult of saints scandalises many of you, and you think they are prisoners of the Church. But it is the Church which is their regal prisoner. Alive, they gave everything. Dead, they provide living witness, they are her witnesses and her judges'.

ANDRÉ DE SCHUTTER,
the Damien Foundation, Belgium.

Notes

[1] Work of reference: *La Lepré*, coord. Université Francophones (Ellipses, Paris, 1995). H.Sansarricq, '38431 Egalement "Santé du Monde"', journal of the WHO.

[2] *Le Père Damien* (Cerf/Racine, Paris, 1999), 351 pp., original edition in Dutch, 1997. English version: *Molokai. The Story of Father Damien* (Alba House, New York, 1999).

[3] Eynikel, *op. cit.*, p. 170.

[4] *Ibid.*, p. 175. Most of our data come from the fine book by H.Eynikel.

[5] From Chapman to Damien, 4 Feb. 1886: 'receive this letter as a weak homage of my affection for you; you have revealed to me what heroism is'. From Chapman to Damien: 'allow me to pray for you and for myself, united in the same faith and the same church, we will receive one day the same crown', Paris, 1940, pp. 204-206.

[6] *Histoire Universelle des Missions Catholiques* (Grund, Paris), Vol. 4, p. 40.

[7] *Damien, un Portrait* (Service de Presses de l'Archeveché, Brussels, 1994). Who still remembers St. Alicee di Schaerbeek in Brussle who died of leprosy in 1250?

[8] Casterman, Paris-Tournai, 1953, p. 185.

The Lok Seva Sangam

Our commitment to combating leprosy in Mimbai began in the early 1970s. There were three of us, all missionaries of the PIME (the Pontifical Institute for Foreign Missions) - a medical doctor, a nurse and myself, a social worker.

In 1976 we registered an association called the 'Lok Seva Sangam' (the association for service to the people) and the health authorities of Mumbai allocated to us two districts of the city which at that time had a population of a million inhabitants. Because these areas were on the outskirts of the city the population doubled in the space of thirty years. With the help of about thirty paramedics we explored all the poor areas entrusted to us in order to discover the first symptoms of leprosy and by the 1980s we were looking after about four thousand lepers. With the arrival of refampacine and multiple treatment the number of lepers registered with us as being under our care was reduced to about eight hundred.

This was without any doubt a success, even though of course it had its limitations because the number of new cases has not diminished and until an effective vaccine is available it will not be possible to prevent the disease.

During this period our co-existence with the lepers has brought out needs other than care and treatment, and these are as follows:

– the need to look after elderly people and the deformed;

– the rehabilitation of those who have been cured.

For this reason, a new project became necessary and this we launched forty kilometres outside Mumbai. We called it Swarga Dwar (Gate of Heaven). This is not only a rehabilitation centre and a hospice. We also call it an ashram, that is to say a place for reflection and prayer. After realising that lepers, as a category, have messages to give to society, I thought it was a good idea to prepare a place where these messages can be given voice to and diffused.

What are the Messages of the Lepers?

– Death, of which deformed lepers are the image, is not the end, but only the gate to the future, the gate to heaven. This is why our ashram is called Swarga Dwar.

– Lepers have always been 'discarded stones' and thus refer us back to the 'discarded stone' *par excellence* – Jesus Christ. They remind us that the Kingdom of God is founded upon a discarded stone.

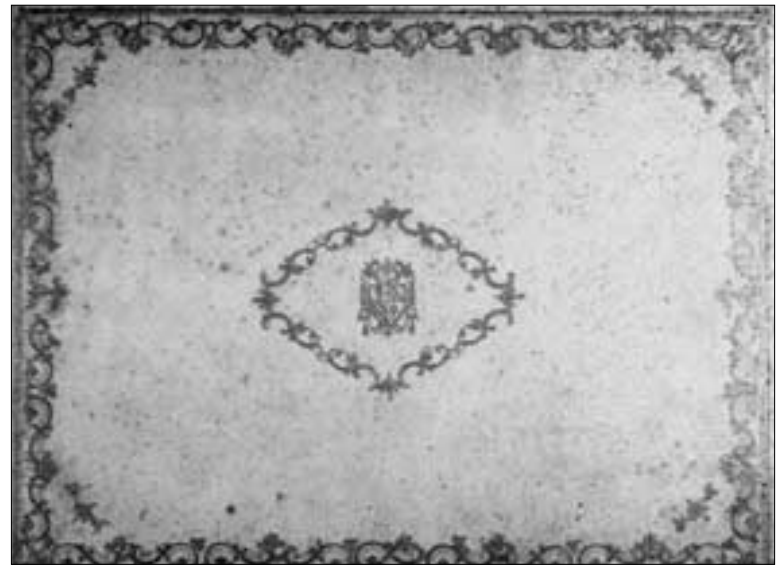
– The 'lepers who have been healed' remind us that the Kingdom of God is near.

– The lepers, with their faith, have pointed out to me the path of religious dialogue.

I realised that the most radical rehabilitation of a person does not so much involve giving him work but rather in making him aware of the fact that he has a mission. If they understand that as lepers they are prophets with a message they will also have a reason for living.

Rev. CARLO TORRIANI,
Missionary of the PIME

Leprosy in Mozambique



I would like first of all to thank the organisers of this symposium for having defined me as being a 'leprologist', but I would not like to usurp titles which do not belong to me: I must therefore make clear that I am simply a voluntary medical doctor who has spent the last ten years in Mozambique, chiefly as an 'adviser' to the 'National Programme for the Fight Against Leprosy'. I have, therefore, an experience of management, and a little clinical experience gained in the field, but I believe that this is not enough to define me as being a 'leprologist'.

Other friends and colleagues here present have a human experience which is certainly much more interesting than my own and much longer in duration which they can present to you and share with you. I would like, rather, to take advantage of these ten minutes to share with you certain reflections on the recent past and on the present state of leprosy in Mozambique, the programme for the fight against this disease, and a number of concerns about the future of those afflicted with leprosy at the beginning of the third millennium.

When I started working in Mozambique in 1999 other colleagues before me had already over the previous six years carried out very qualified work which was very important for the organisation of the 'Programme for the Fight Against Leprosy' and in the introduction of polychemiotherapy in extremely difficult conditions – a country in a state of civil war in which it was often very difficult to satisfy even the most elementary needs of survival. However, the work carried out by these colleagues, both from Mozambique and abroad, permitted the implementation of the programme and the beginning of the polychemiotherapy suggested by the World Health Organisation. Unfortunately, it was possible to reach only 7% of the approximately 19,000 people suffering from this disease who had been counted. We were thus faced with the need to find a different strategy in order to reach as soon as possible all the people suffering from this malady, to assess them clinically, and to begin a suitable treatment for all those who were clinically active.

At the beginning of the year 1991 we were able to partly change the regulation of the Ministry on Health on the employment of antibiotics for these sick people. Whilst previously the ability to prescribe such drugs was confined to medical doctors who were leprologists (there were only two in the whole of the country) and to the provincial supervisors (eleven in number), from April 1991 onwards these drugs and medicines could also be prescribed by 'nurses suitably trained' in making a diagnosis and providing forms of follow-up treatment to people afflicted with leprosy.

The basic condition imposed by the Ministry of Health was the existence of qualified nurses – in August 1991 we thus began national training courses on leprosy of four weeks in duration for district nurses. A premise is required with regard to the level of academic training of these nurses and their 'relevance' (at that time) to the programme. Most of the nurses were (and still are) at a basic level, that is to say they had reached the sixth elementary class and followed a health care course for a year and a half. Many of them had difficulties in reading and writing correctly in Portuguese. Furthermore, many nurses attached to the programme had been sent to join it as a punishment because they were alcoholics or because they had committed serious disciplinary errors or because they were not reliable at work. This was the human material which was available at the outset.

I should say that a large part of these people are still attached to this programme even though at the present time they have completely different motivations for being a part of it. On the other hand was it not said that 'the stone thrown away by builders has become a cornerstone'?

For such personnel, therefore, we had to 'invent' simplified diagnostic and classifying methods (even at the cost of a certain loss of quality). We thus decided in drawing up the first reference book for the programme to abandon the Ridley and Joplin system of classification and adopt the simplified

classification based upon 'paucibacilli' and 'multibacilli' infected people which had been proposed by the World Health Organisation. The difficulty lay in providing clear (and in a certain sense Salomonic) indications as to what was meant by paucibacilli and multibacilli. A publication by a group of leprologists from Adis Abeba came to our help indicating a good system (even though to the detriment of specific determination) whereby it was established that the PB were cases with a maximum of five hypopigmented marks and that the MB were all the other cases. With regard to the peripheric nerves, the PB were those with a maximum of affected nerves.

Please forgive me if I am boring you with such technical information but such information is of help in demonstrating to you the level of simplification which we had to adopt in order to implement the programme given the conditions which prevailed (and to a certain extent still continue) in the country.

This kind of classification, which has been adopted by us since the beginning of 1992 and was initially criticised by a number of experts of the World Health Organisation, was subsequently officially accepted by the World Health Organisation itself in 1995 with the publication of its 'Guide for the Elimination of Leprosy as a Problem of Public Health'. In this guide there was expounded exactly what the programme in Mozambique had been applying for a number of years, that is to say the bacilloscopy of leprosy. It was NOT essential for the diagnosis and classification of those afflicted with the disease. The diagnosis, and I emphasise the point, the classification, and the choice of the form of treatment, could be made exclusively on a clinical basis (the type and number of skin lesions and affected nerves).

The adoption of these and other simplified norms allowed us to be able to use to the utmost the personnel and the resources which were available, to progressively expand our diagnostic and therapeutic activity to all the accessible zones of the country, and to establish the conditions for a further expansion once the civil war was finished and the conditions for moving about the country had become even minimally secure.

From 1995 onwards all the districts of the country had a nurse able to diagnose (at a reasonable level of reliability) and to treat leprosy, and at the end

of 1996 100% of the registered cases were receiving MDT in conformity with the schedules of the World Health Organisation. These schedules envisaged polichemiotherapy treatment with two drugs for PB patients over a six-month period and three drugs for MB patients over a period of twenty-four months. A certain corpus of clinical studies had clearly demonstrated the effectiveness and safety of this system of treatment, which, indeed, provided for the cure of 100% of the people infected with leprosy, with a relapse rate of 1% after ten years.

These very effective systems of treatment allowed us to heal about 14,000 patients and to progressively reduce the total number of people with this affliction who were being treated from more than 19,000 in 1990 to about 10,5000 in 1997. The improvement in the 'image' of the programme, together with research into patients who had previously been registered and a clinical assessment of their condition, and the active screening of, and provision of health care education to, the population, enabled us to obtain a contemporaneous increase in the discovery of new cases – in the nineteen eighties less than a thousand cases were discovered each year but in the middle of the nineteen nineties more than 4,000 new cases were discovered each year. This suggested that these cases were really new cases and were discovered at what was a relatively early stage in the development of the disease.

It was however already evident in 1997 that Mozambique, like the other countries of the world, would not be able to reach by the year 2000 the objective of the 'elimination' of leprosy (defined as a reduction to a level of incidence of less than one active case every 10,000 inhabitants – a level at which it is believed there is no threat to public health). The extrapolations which we made allowed us to envisage a possible 'elimination' of this disease by the years 2003-2005.

In the meantime, in 1997, the World Health Organisation summoned a group of leprosy experts to assess the existing situation in the world and to produce a strategy for subsequent years. This group of experts advanced a number of observations and proposals, one of which, in my opinion, is of fundamental importance for the future of those people who are afflicted with leprosy.

I will try to summarise it and make a number of observations about it to the members of this symposium.

It was said that the clinical classification which is employed (that to which I recently referred) 'exaggerated' in its classification of leprosy patients. Most of the sick people clinically classified as MB subjects, it was asserted, were in fact PB cases and could have been treated with a system of shorter duration, that is to say not with a treatment which lasted twenty-four months but with one of twelve months' duration.

I completely agree with the statement of the World Health Organisation that most of the people classified as MB are probably PB. Our experience shows that 86% of the MB cases have in fact very few bacilli in their bodies (that it so say

they have a bacilloscopy at the time of diagnosis of 0, 1, or 2) and only 14% can be defined as being 'highly bacillary'. The real problem lies in the suitable identification of this sub-group of patients who have to be continued to be treated for twenty-four months (or at least for more than eighteen, as is demonstrated by a number of clinical studies), for if they are not so treated they run the risk of having relapses after a number of years, perhaps with bacilli which are resistant to the antibiotics which have been used.

It should be said that no controlled clinical study exists today which demonstrates the effectiveness of twelve months of treatment for MB patients. A study is currently underway but we are not aware that its results have been published. In an epoch which is considered 'scientific' every change in a system of treatment should be matched by scientifically controlled clinical studies, unless, that is, the third millennium means a return to a pre-Galilean form of science.

In the situation which now reigns in Mozambique (and I believe in many other developing countries) a separation of high bacillus incidence patients from the others is absolutely impossible because it would require the systematic employment of a bacilloscope at the moment of diagnosis. Only one microlaboratory exists in each district in Mozambique and the various outlying health care centres chosen for the organisation of the diagnosis and treatment of leprosy victims (in order to facilitate access to treatment and their engagement in treatment) are from between twenty-five to a hundred and twenty kilometres from each other. For this reason it is not possible to identify this sub-group of high bacillus incidence patients, who, and I repeat the point, in actual fact cannot be cured by the twelve-month treatment which is proposed by the World Health Organisation.

In 1997 we were preparing a new version of the handbook on leprosy, which at that time had run into trouble over the question of the duration of the treatment of MB patients. A series of letters from the World Health Organisation (three to be precise) to those in charge of the programme in Mozambique, and a seminar which was held in Abidjan, convinced the Minister for Health of Mozambique to accept the treatment of twelve months' duration.

Together with other factors, this event was what led to my decision to resign as a consultant to the leprosy programme in Mozambique.

I find the decision to reduce the length of the treatment which was promoted (if indeed not imposed) by the World Health Organisation does not in the least take into account the needs of those people suffering from leprosy, and sees at least a percentage of these people considered as a whole as an epidemiological quantity and not as people with a right to effective treatment.

I believe that it is neither scientific nor ethical to substitute a treatment which has been demonstrated to be effective in practically 100% of cases and to introduce a shorter treatment which deliberately leaves out (or runs the risk of not healing) 14% of these afflicted people.

I have a few doubts which I would like to share with you, and they are as follows:

– What was the use of shortening the duration of the MDT less than three years from the difficult year 2000 by which time leprosy was to have been 'eliminated'?

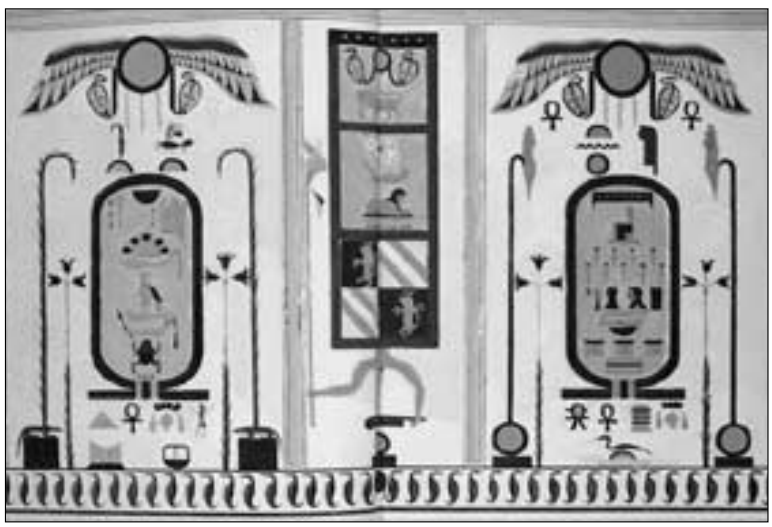
– Was it perhaps useful to artificially reduce the total number of those suffering from leprosy in order to achieve the aimed-for goal on paper?

– Or was there a need to reduce the cost of the treatment provided to these sick people, something which depends on international donations?

I would not like these questions to appear as malevolent inferences during a Holy Year when on the contrary we should strive to identify positive elements. But I am worried about our brethren who are afflicted by leprosy. For thousands of years they have been demoted, isolated from society, and hidden from view. Perhaps we have today found a new system of segregation by declaring that all of them are cured within twelve months, eliminating them from the registers, and leaving them to a destiny where in five or ten years they will present relapses when the various national programmes of the fight against leprosy have been dismantled, given that leprosy will have been removed from the number of problems for public health.

I would like the forty-seventh World Day of those Afflicted with Leprosy which we are now preparing for (the first such day to take place in the new millennium) to be not only the celebration of a regular event but something which conserves its purpose – that is to say the stimulation of consciences in relation to the problems which society still creates for these afflicted people.

Dr. LEONIDA COMPOSTELLA
Head Medical Doctor,
the Homoine Project,
Mozambique.



Rehabilitation Needs in Leprosy

Introduction

To discuss the rehabilitation needs of persons affected with leprosy, let us first look at the present situation of leprosy. At present, every year there are about 800,000 persons with the active disease while the number of persons who had the disease in the past and who have been cured of the bacterial infection are about 11-12 Million. It is difficult to say how many other persons there are in the world who have the infection, either in a sub-clinical phase or with clinical signs of the disease, who have yet to be diagnosed.

A second important aspect which needs to be understood is the concept of *prevention continuum* for rehabilitation. If the disease can be prevented, before the onset of infection, for example through vaccination, this is called *primary prevention*. At present, we do not have any tool for the primary prevention of leprosy. Once the infection takes place, and if we can prevent the onset of disabilities, this would be *secondary prevention*. Finally, if the disease has already caused disabilities, it is still possible to promote *tertiary prevention* so that existing disabilities do not worsen and no new disabilities arise. In the case of leprosy, both secondary and tertiary prevention are possible and needed.

The third general concept for understanding the issue is that of *impairment, disability and handicap*. The disease can lead to a physical or physiological malfunctioning of the body, for example, the paralysis of a muscle and this is called impairment. Due to the impairment, the person may be unable to carry out some activities, for example, if a person has a paralysed muscle in the leg, he/she may not be able to stand or walk properly, and this is called disability. The disabilities can have physical and/or social consequences leading to handicap, for which physical, cultural and social barriers posed by society are very important.

In the case of leprosy, it is known that *social disabilities caused by stigma* play an important role in the disabling impact of this disease in the lives of persons. Thus, even in persons without any physical consequences of leprosy, there may be negative social impact on the lives of persons. Even the family members of persons affected with leprosy may face social disabilities.

It is estimated that there are about 2-3 million persons with visible physical consequences of leprosy. At least theoretically, all the 10 million or so persons who have completed MDT can be at potential risk to the social consequences of leprosy.

The term "*rehabilitation*" refers to a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric and/or social functional levels, thus providing them with the tools to change their lives towards a higher level of independence (UN standard rules 1994).

Leprosy affects the peripheral nerves in the whole body producing loss of sensation and even muscle paralysis, though it does not involve the central nervous system (brain and spinal cord). The nerve damage can be slow and direct or it can also be sudden and indirect through complications like leprosy reactions.

As there is no primary prevention for leprosy, the only way to prevent the physical disabilities caused by leprosy is through early detection of new cases and their proper treatment through MDT. At the same time, the leprosy reactions need to be treated early and adequately. However studies have shown that new disabilities may arise even after starting MDT and this may indicate the lower priority given to prevention of disabilities and rehabilitation activities in a leprosy control programme. It is important to remember that leprosy reactions and related disabilities can occur even after the completion of MDT when the person is already "cured".

Apart from persons having a visible disability due to leprosy, there is another risk group of leprosy affected persons, *persons with only a loss of sensation* in the feet, hands and eyes. These persons are at a high risk of developing disabilities and they need lifelong care to prevent these complications. It is estimated that there may be 2 million persons in the world with Grade 1 disability (loss of sensation without visible disabilities).

Physical disabilities caused by leprosy affect the hands, feet and eyes

– In feet starting with loss of sensation, toe clawing and foot drop progressing to loss of toes and bones with deformities, which may need amputation.

– In hands starting with loss of sensation and clawing of fingers progressing to loss of fingers and bones with deformities, which may need amputation.

– In eyes, starting with loss of corneal sensation and inability to close the eyes, progressing to complete loss of vision.

It is important to remember that this progression of disabilities in hands, feet and eyes is not inevitable and can be prevented by early diagnosis, and self-care of body parts with loss of sensation. Even after the disabilities have set in, they can be reversible in the early phase and worsening of disabilities can be prevented through adequate self-care and referral services.

Main rehabilitation needs of leprosy affected persons can be summarised as:

– Life Long Self Care: Once a person has chronic loss of sensation or disabilities are already there, the person needs life long care.

– Protective Footwear: This is useful for persons with loss of sensation in the plantar surface of feet, so that plantar ulcers can be prevented. Ideally, persons having loss of sensation in the feet should be issued with protective footwear, before the appearance of first plantar ulcer, though in practice this does not happen often.

– Plantar Ulcer and Wound Care: Once a person has a plantar ulcer, he/she needs care in healing it and preventing it from getting deeper and reaching the bones.

– Physiotherapy: This is indicated for taking care of paralysed body parts and in pre-operative and post-operative phases. Given the need for life-long care, the role of the physiotherapist must be that of a teacher in self-care skills.

– Orthopaedic Appliances and Mobility Aids: Persons having drop-foot or amputations need orthopaedic appliances and mobility aids. Sometimes even simple appliances like gloves can play an important role in preventing development of serious disabilities.

– Surgery – Corrective, Demolative and Cosmetic: If the disability is not long standing and if the person has been able to maintain flexibility of joints through proper exercises, surgery can be useful. Though surgery may be seen as too costly for the amount of benefit it can provide to a limited number of persons, it may play an important role in raising awareness about the leprosy programme in the area, so that new cases of leprosy can be detected in an early phase, before the onset of disabilities.

There are also the *socio-economic rehabilitation needs* of leprosy-affected persons which can be summarised as:

– Psychological Support and Counselling: These can be related to poor self-image as well as to social taboos related to leprosy in the community.

– Vocational Training and Occupational Rehabilitation: For persons who have lost their job or who cannot carry out their previous work, vocational training and occupational rehabilitation can play key role.

– Job Placement and Loans for Self-employment: A formal job placement for a leprosy-affected person is not easy and can benefit only a limited number of persons. Thus major emphasis is given to promoting loans for self-employment.

– Special Needs of Old Leprosy-Affected Persons With Severe Disabilities Living in Leprosariums: Old persons with chronic disabilities living in leprosariums may not be able to become self-sufficient and need life long care in institutions.

The changing situation of leprosy-affected persons and their needs – The situation of leprosy has changed radically over the last few years. Previously the number of active cases needing drug treatment was high and less importance was given to ex-patients and espcially to those living in old leprosariums and leprosy colonies. Now, in some places, the numbers of ex-patients can be much higher than the registered cases. For example, the following information (1998) from Vietnam illustrates this situation:

– 20 Old Leprosariums with 3,971 Leprosy Affected Persons

– Total Registered Cases 2,876

– Total New Cases During 1998 1,751; of whom, 29% with visible disabilities and 12% with Grade 1 disabilities at the time of diagnosis. This is in line with what Prof.

Smith said earlier. If we consider the number of ex-patients living in their communities, outside the leprosariums, the number of persons with rehabilitation needs is quite significant.

Rehabilitation Needs: some Key Issues

– Information about persons with grade 1 disabilities (only loss of sensation and no visible disability) is not available. Even for persons with grade 2 disability (visible disability) the information available at national level is very often incomplete. Thus, without knowing the different needs, it is not possible to plan adequate interventions for answering those needs.

– Mainstreaming: Like all the other disabled persons, persons with leprosy-related disabilities should receive rehabilitation services from existing medical, social and other services rather than having separate services. The fact that the majority of leprosy-affected persons live in their communities also imposes this kind of choice.

– Primary health care services are supposed to address the main health problems in the community, including promotive, preventive, curative and rehabilitative services for disabled persons. (1978 Declaration of Alma Ata). Still, a lot needs to be done to achieve this goal.

– The term *equalization of opportunities* means the process by which the various systems of society and the environment, such as services, activities, information and documentation, are made available to all, particularly to persons with disabilities. This is important to ensure that leprosy is not seen as something special only for a few persons but that leprosy-affected persons have the same rights as all other persons. The principle of *equal rights* implies that the needs of each and every individual are of equal importance, that those needs must be made the basis for the planning of societies and that all resources must be employed in such a way as to ensure that every individual has equal opportunities for participation (UN standard rules 1994).

– Community based rehabilitation (CBR) is a strategy within community development for the rehabilitation, the equalization of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of the disabled people themselves, their families and communities, and the appropriate health, education, vocational and social services. CBR can play an important role in reaching those persons living in the community.

Global Alliance for Rehabilitation: Working Together for the Consequences of Leprosy

Some Ideas for the Near Future: Given the present situation of the rehabilitation needs of leprosy-affected persons, Amici di Raoul Follereau (AIFO) proposes the launching of another global alliance involving all other NGOs working for leprosy affected persons and with WHO and other partners, so that strategies can be defined to obtain more information about rehabilitation needs and to promote sustainable rehabilitation services focusing on the self-sufficiency, development and human dignity of leprosy-affected persons. AIFO proposes to organise an international workshop in collaboration with the Disability and Rehabilitation Team of WHO, before the end of 2000, in order to:

– Verify the existing materials related to rehabilitation of disabilities due to leprosy.

– Prepare teaching materials for promoting specific rehabilitation through PHC.

– Prepare teaching materials for promoting socio-economic rehabilitation through CBR.

– Field test the teaching materials and rehabilitation strategy.

Dr. ENRICO PUPULIN
Chief Medical Officer
Disability and Rehabilitation Team (DAR)
World Health Organisation (WHO)
Geneva , Switzerland

Dr. SUNIL DEEPAK
Medical Director
Amici di Raoul Follereau (AIFO
Bologna, Italy

The Newsman and those Suffering from Leprosy

This is not a conference, it is witness. This is not a paper on Follereau, esteemed teacher of good and sharing. Many people have spoken about him, and they are far more authoritative than I am. This is purely and simply, and I repeat the point, an act of witness. I am an old newsman and I have travelled round the world for fifty years, above all in the third world. This old newsman has encountered leprosy and I have seen lepers live and die. I have drawn from this unique experience a great lesson, which is even banal in its immensity, and that is, dear friends, that life, the gift of God, should be lived until the last day, whatever our physical conditions may be.

The previous paper on disabled people struck me a great deal. This is a curse of our society and as the speaker rightly said, we should make them feel as we are, above all else in psychological terms. I was young, very young, a sort of *enfant prodige* when, during the 1950s, let us say half a century ago, I worked for a newspaper which in those times was a great newspaper and it was called 'Il Tempo', founded and edited by an extraordinary person, Renato Angiolillo.

One day he said to me: "do you feel like going to a leper colony, to live there for a few days and write an article on 'leprosy experienced from within'? I answered: "where, in Africa?" "No, not in Africa, in Italy", replied Angiolillo. "You do not know that at Acquaviva delle Fonti, near Bari, at the Miulli hospital, there is a ward reserved for leprosy victims". "To be precise", my editor of those days said to me, "there are fifty-three lepers". "The secretary of that leper colony", continued Angiolillo, "Prof. Ciccio Pepe, is a very good friend of mine. So you could stay there, taking the guise of a medical doctor. Pepe agrees because it would be a matter of giving a hand to those poor unfortunates."

I answered my editor: "very well, but on a condition – I do not want to go in disguise. The sick people there must know that I am a journalist who respects their suffering, but a journalist. If they accept, all well and good, if not, we will not do anything".

They accepted the idea and so it was that I began my journey to that leper colony. I have to say, I have to confess, that at that time I had a biblical vision of the disease as something which was monstrous and terrible. I expressed my fears before entering the leper section to offer my service to a very dear friend of mine, Vittore Fiore, a historian and eminent sociologist from Bari. And he answered with great simplicity: "why don't you go to see Padre Pio and get yourself blessed?" Just think, already then, in 1949, and here we are at the end of February 2000, Padre Pio had a reputation for saintliness.

I do not want to go on too long. I had a meeting with Padre Pio, which was very special. I listened, and felt with a mixture of amazement, on the brink of fainting, that my finger entered the palm of his hand. I received the blessing of this rough but holy Capuchin and I then went off to that leper colony.

I reached Miulli hospital. Now I will read you a piece from my report of that time, of a half a century ago: 'the hospital of Acquaviva delle Fonti rises in the heart of this ancient and kind city where theft and crimes never take place (at least so far) and the people speak an imaginative and communicative dialect. The right wing of the building is isolated from the rest of it and has fifty-three sick people who are not ordinary types – lepers! They are fifty-three humble and serene individuals – thirty-one men and twenty-two women'.

And here I say how they are entrusted to the care of the professor of dermatology etc. etc. and to Prof. Francesco Pepe, the secretary, a romantic and active man who had been living (I

was writing then in 1949) amongst the lepers for twenty-two years and who for them is a friend. In my report I went on: 'In Italy itself, it should be borne in mind, and this can serve as information for scholars of statistics and medical doctors, in Italy the only real and authentic leper colony is here at Acquaviva delle Fonti. In Messina, Cagliari and Genoa there are isolation wards for lepers in the local hospitals.

Since 1927, the day of its creation, that is to say the national leper colony, two-hundred and forty-six sick people have passed through Acquaviva delle Fonti – one hundred and forty-five men and one hundred and one women. In the whole of Italy the number of official leprosy cases which require compulsory hospitalisation are not above four hundred and fifty.' Then I went on: 'the most recent forms of treatment (this again is half a century ago) of sulphone with streptomycin are providing remarkable results, according to what I am told. It is still too early to say that leprosy has been defeated but science does not despair of being able to contain it. The bacillus of Hansen, imported into Italy at the time of the holy wars, as was the case in Scandinavia where it displayed exceptional virulence, cannot be cultivated and hence the impossibility of carrying out studies based upon secure experiments are not possible'.

There was another interesting thing for me. 'Medical doctors usually distinguish, (or at least such was then the case), between three forms of the disease – nodular tuberculin leprosy, anaesthetic or nervous leprosy, and leprosy made up of both these previous forms. It is a contagious disease, especially in its nodular form, carried through nasal mucous, hence the need for strict isolation. Indeed, the leprosy pandemic, from the Middle Ages until today, that is to say 1949, has lost its intensity and diffusion. The most important outbreaks are to be found in Scandinavia but the excellent and inflexible legislation inspired by Dr. Hansen, who discovered the bacillus in 1871 (I have seen it under the microscope, it is like a bunch of cigars), has greatly reduced its incidence. And with absolute isolation and the latest scientific discoveries, sulphon and streptomycin, a leading doctor told me, we can hope to make further progress.'

I had made a whole host of notes when the secretary said to me: "Do you want to see them? Do you feel like it?" "Certainly", I replied. He made me put on a coat and we went off. Before opening the door which led into the leprosy section the secretary waned me: "control yourself even if you have a sense of revulsion. The lepers are good people but they become bad if they realise that they disgust you. Leprosy is an illness which even leads mothers to reject their children with disgust. A similar incident happened here. Once a leper put his finger in his nose, wet his nails, and attacked a nurse by scratching her face". "They are good", said the secretary, "but they can become bad".

We went in and some women in white blouses met us, about five or six. They had a ribbon in their hair. They had done themselves up in my honour, but their hands were like fencing gloves. And their faces were contracted. Because leprosy is a merciless disease and strikes the face first of all. "These are the least devastated", Prof. Pepe warned men. "It is they who are greeting you because in this way you can get used to things slowly". So much sensitivity moved me, and still moves me. They drew near to me and bid me welcome. I was led by instinct to give my hand to the woman who was nearest to me, but she stepped back. "Be careful", said the woman leper, "it can be dangerous". And she smiled as though she wanted to apologise.

And with these words the secretary, Ciccio Pepe, drew near to the woman, took her hands in his, shook them affectionately and shaking those fencing gloves, her hands, which were deformed and horrible, in the sight of that woman, placed a kiss on her forehead. This was a forehead covered with nodules. I asked him if he was ever afraid of catching the disease. And the good Prof. Ciccio Pepe answered my question with a single word – "no". And he immediately added: "thanks to Follereau". But not knowing who he was I said: "what is it. An antidote? A remedy?" This was in 1949. And Pepe, looking at me with a mixture of tenderness and compassion, answered with a certain pride: "No Igor Man, it is the name of a saint, a secular saint, Raoul Follereau". "He is a lay missionary", he continued, "somebody inspired by God, a messenger of Christ. He and his wife decided to alleviate the suffering of leprosy victims, to abolish the medieval image that we have of them, a cruel and superstitious vision of the leper who has to go around with his face covered sounding a bell to warn people that he is coming. Follereau has de-mythologised leprosy", this gentleman continued. This was fifty years ago. "It is a disease like any other and you can recover from it." Dear friends, this is what the simple and very human Don Ciccio Pepe, the generous secretary factotum of the hospital of Acquaviva delle Fonti, said to me.

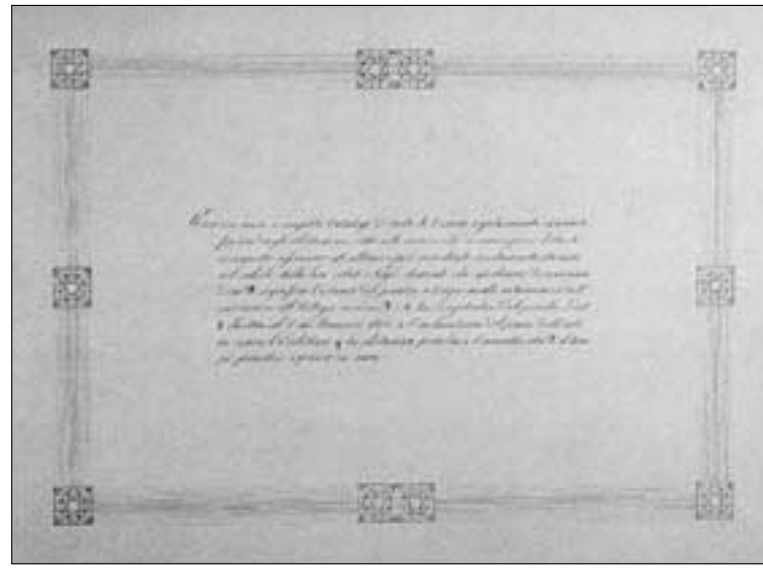
And thus it was that I heard

for the first time in my life of Follereau. I think that at this point it would be a good idea to tell you about a single episode of that unique experience of 1949. To be exact there have been three moments which have shaped my working life: the meeting with the lepers, intimately connected with Padre Pio; the Vietnam war; and being put up against a wall in the Sudan and not knowing for a full half hour if they were going to kill me and if I would be able to return to my home and my wife and children.

And thus, to go back to my experience at the leper colony, at a certain moment a female nurse came up to me and said to the secretary: "Professor, Caterina is waiting for you". Don Ciccio Pepe then said to me: "you see Igor Man, yesterday I spoke to you about a person who is really saintly. Now you will meet her". This person was Caterina Herr. Now I will speak to you in the present tense because I want to reproduce exactly what I wrote at that time. This saintly person is Caterina Herr of Cuneo. She is seated on a deckchair, her hands on her lap, a black cap on her head, her eyelids down – the only human trace on a face which has dried up like a prune.

"Good morning, Caterina". And she comes out of a sort of hibernation, moves, leans forward because she is blind – leprosy has corrupted everything in her frame. And she answers: "good morning, welcome!", with the usual acute falsetto voice of lepers who are most struck by the disease. One thing always struck me when I met lepers – their voices. There is obviously a scientific explanation because the vocal chords are clearly affected by the disease.

Her voice stridulates, I would say that it is a voice which cuts you, it cuts into your heart like a bad knife. She is horrible and pathetic. A nurse takes here by her forearms and shows me with a professional movement, turning over her wrists, Caterina's arms – two formless bagfuls of squashy flesh. They explain to me that the nerve form of leprosy makes the tissue retract. The fingers withdraw like those camping beakers which boy scouts have, in aluminium, which they can fold up and put in their pockets.



The nurse also tells me that the feet are the same. Caterina has not stopped smiling, on her face there passes a shadow of indulgence which is imperceptible. She did not ask me to look at her former hands. She wants to tell me that she has composed a poem on the victory of the forces of good over the anti-Christ. Caterina was eighteen years old when she fell victim to the malady. At that time I wrote: "she has lived dying for forty-seven years". She did not know how to read or write when she arrived at delle Fonti. She learnt before she went blind. Now she spends her dark and silent days composing verses by heart. This is the force of life! She provides light, awakens the sounds within her, with her poems. She recites one of them to me. It is made up of a few verses, a sonnet, simple stuff. Elementary but absolute verses. "When the cross was given to me, bending myself, I took it in my arms". Resignation was transmuted into joy. What are my sufferings, she asked herself, compared to those endured by Christ and those which mankind inflicts every day? "The Cross unites me to Him, I suffer for Christ and I am not embittered". She suffers in a serene way, to expiate her sins and those of the world, waiting, she concludes, for the shining dawn of the day which will not end.

I came near Follereau, and brushed close to him a number of times, but we never met. But travelling in Africa in particular and in India, we brushed close. I, too, visited the famous Dr. Albert Schweitzer, an extraordinary person, the comforter of the afflicted, but at the same time a colonialist, a kind of Bismarck, rough in his manners, disdainful, there at Lambarenè. I remember that when he brought us breakfast in the morning the servants were all bound up, they had marks under the coverings – they were lepers. By then I knew about this, I had had similar experiences, and the thing did not make any impression on me. But there was an English journalist from 'The Sunday Times' who was terrorised – he peeled his papayas with his own hands. (It is said that the incubation period for this disease is five years – by now I have escaped it!). Schweitzer played the piano at night and Mr Schweitzer won the Nobel prize in 1952, if I am not mistaken. And Follereau, in his infinite and childlike goodness, was

greatly affected by this. With all respect for Schweitzer, I prefer the anonymous saint Follereau.

Mother Teresa was very attached to Follearau. Both had seen and experienced how there was, as there is today, a sinister marriage between leprosy and hunger. On 2 March 1963 in Turin Follereau held a conference at the Carignano theatre. Among other things he said: "In Calcutta miserable people are dying on the street in their hundreds, do not tell me that it is revolting. The first time I went I was terrorised at the idea that I had to tread over these dying people and these corpses. But yet, and this is the worst thing, after fifteen days I was doing the same as everybody else".

The same thing happened to this humble old newsman in Benares. I walked over carpets of lepers who in the place of their noses had a kind of warped mandarin. "In Calcutta", he continued in his famous speech which shook the whole of Turin, "there is cold, and this is a good thing! There the police must take the dying people from the streets and take them to three hospitals, one after the other. If these hospitals refuse to take them in, and they always refuse because they are jam-packed, the police have orders to take back these unfortunate people to where they found them, and these people end up by dying on the pavements or in the gutters." When Mother Teresa went in 1965 the situation was the same, and I believe that it is still the same.

And Follereau went on by saying that Sister Teresa had said: "No, I cannot sleep without nightmares, I cannot eat well knowing that every night, in front of my door, in my street, there are our unhappy brothers in God who are dying". So Mother Teresa, went on Follereau – by the way I think this conference is an extraordinary, incredible, account! A person of the profession can make the observation. Well Mother Teresa, Follereau went on, "went to the high priest of Kalì, who was amazed at the enlightened charity of this missionary and gave her half of his temple so that she could make what she called a hospital for the dying, that is to say a decent warm room for the living".

You know that Mother

Teresa was often attacked in various places with the words: "what is she doing, helping people who are dying?" Well, does that seem to you nothing. From that moment Mother Teresa, helped by young Indian women, has walked the streets of Calcutta, collecting dying people and taking them to that place where they die not like dogs but like men. And here I would like to add to the words of Follereau that the great thing about Mother Teresa was that she washed the dying person, she gave him something to eat, and so did her sisters, she helped him to experience his religion at every second. That is to say she did not try to prevaricate. This, I am told by very authoritative people, struck and amazed the Holy Father when he went down there to visit Mother Teresa. And Mother Teresa took him by the hand and together they went to perform this service. That is to say, they allowed the Son of God to die with the ritual words of his religion, as a sign that there is one God, unique, one, compassionate and merciful.

Follereau went on and referred to an episode. "I want to read it to you because it is really terrible but will show that we are not engaging in ideal chatter and we need to become aware that we are not like all these people attached to sick people, sacrificing themselves day after day. We must become aware and perhaps, I do not say be ashamed of our way of being, but of our shallowness, of our neglect".

"Well", said Follereau, "I was in Calcutta when Sister Teresa telephoned me at Kalinga and said that in a 'hospital for the dying' a young leper girl was about to die. I went there. She was a woman who according to the birth register was twenty-two years old. She was more or less my height, she was a normal woman and she had had two children. I saw her there, powerless as I was, exit from her existence with convulsions. When she died I had the impulse to weigh her. Sister Teresa and I took this small body in our arms and put her on the scales. This woman, who was twenty-two years old, as high as me, weighed twenty kilos."

"I realised", Follereau went on, "that in this world, in this twentieth century of Christianity" – because that was the century – "there are unfortunately other forms of leprosy, and not that to which I had consecrated my life. There are other forms of leprosy which are more contagious and more terrible than leprosy and for which there is no comfort except our love. And the first of these leprosies is hunger. Hunger means that today two-thirds of mankind" (this was a conference held in 1963) "just think – two-thirds of humanity, two men in every three, do not have enough to eat. Hunger means that every year people die, not perhaps weighing twenty kilos like the poor leper of Calcutta, but because they do not have enough to eat. Thirty-five million people die of hunger. I calculate that a child dies every thirty seconds – either killed by a bullet or killed by hunger."

Now I ask myself, and I apologise to you if I have di-

gressed too much and I would like to thank you for your patience, I would like to ask in conclusion why this person of contemporary history who has been so widely and so much spoken about, this secular saint who went round the world thirty times in an impetus of love and charity towards his derelict brothers, lepers, and those dying of hunger, why does this man not deserve, on the same level as Padre Pio and Mother Teresa, the so-called process of beatification?

With all respect I think that somebody should reflect on this question and I will go back to the subject in my newspaper, on television, and in the column which I write for "Lo Specchio", the magazine of our newspaper 'La Stampa'.

But to reflect on the question, and here I address myself to those who met him, and I say this with a feeling of sweet envy, is something which is worthwhile up to a certain point. Because dear friends, excellencies, ladies and gentlemen: people, the humble, the dying of hunger, lepers, the people of God, have already made Raoul Follereau a saint.

Professor IGOR MAN,
Journalist,
Italy.

Leprosy: A Word Synonymous with Marginalisation

It is not my intention – and indeed here there would not be space enough for such an undertaking – to propose a historical *excursus* on the role which leprosy, even in relation to its exceptional linguistic connotations, has played down the centuries as a generator of exclusion, of abandonment, and of condemnation. A rich bibliography on the subject brings out how in distant history and also in that history which is near to us, the term itself, used to indicate someone who was afflicted by the malady (today more correctly known as Hansen's disease), or the mere suspicion of the disease, was sufficient to exclude the victim from civil belonging as though he were afflicted by divine punishment, affected my moral impurity, and by sin. And for this reason he was condemned to isolation and thus to a certain death, when indeed this was not actually decreed *ex lege* by the community itself.

I would like to quote from the work by Stanley Browne 'Leprosy in the Bible' published in Italy by the Friends of Raoul Follereau Association: 'the harshest measures of persecution, of forced segregation, of the denial of legal and social rights, of forced separation from families, left their mark in many of the prejudices which today still exist in Christianity'. I would like to add that often hurried readings of the Bible, moralistic interpretations, and inadequate scientific knowledge of the malady linked to forms of popular superstition, perpetuated this discriminatory approach for centuries. Indeed, even today news items report cases in countries, and even in advanced countries, where the segregation of those suffering from this disease, who are isolated from every kind of human relationship, is still a practice which is the order of the day. At times we have the impression that the medieval period, with its fears and its dark visions of life, is still present amongst us.

It is quite clear that in perpetuating this rejection of those who are afflicted with this disease the external manifestation of the disease of leprosy has always played an important role. The deformations and mutilations have generated in the popular imagination and in literature and cheap writings images and descriptions which are not matched in any other form of pathology, even though a number of such pathologies are real and authentic scourges in the poorest countries of the world. One need only think of malnutrition, blindness, childhood mal-

formations, to give only a few examples. Leprosy remains for many people the malady of rejection and exclusion despite the efforts of those many people – Follereau taking pride of place – who have striven to show the baselessness of so many fears, if not in the name of charity then in the name of common sense and reason.

The person who is addressing you now cannot forget the welcome I received from certain colleagues of mine a few years ago after returning from a journey of work to an African leper colony – I was received by some of them as though I was already infected by the disease, and I was even deprived of a simple handshake, you might like to know, if I did not 'purify' my hands first. What, therefore, should all those who spend their whole lives looking after lepers in hospitals and prevention centres do?

Fear generates monsters and monsters feed the culture of exclusion, something which is sinister and irrational and which goes beyond any kind of logical judgement to become a form of unconscious rejection, the homologation of a stereotype which feeds on ignorance and a lack of charity. And which offends the intelligence of the person who embraces it even before it offends human dignity.

What should we say when we see at the stadium banners which attack the other side's fans in an offensive spirit as 'lepers'? Or when a French member of parliament speaks about those sick with AIDS as 'kinds of lepers who provoke the infection through breathing, contact, and saliva'? Or when certain exponents of local authorities in the North of Italy publicly launch the 'leprosy alarm' amongst immigrants on the basis of certain newspaper stories in order to support a policy of expulsions and restrictive measures in the granting of residence permits? And what should we think when we read in newspapers, as happened a short time ago, of an inquiry opened by the district attorney's office of Ancona into a company which distributed a game for children which to say the least was worrying – the game involved the creation through small models of a sort of identikit of people who had to be isolated because they were dangerous and who were characterised by the colour of their skin, their clothes, and their social condition. Amongst these people, in the company of monsters and international criminals, there were also lepers.

Comments are superfluous but we should think about the possibility that our society has before it of neutralising these forms of marginalisation and racism and of transforming a culture of rejection into a culture of welcoming and solidarity. As 'one who belongs to the trade', as a journalist, I believe that a role and special responsibility also lie with the world of communication understood in its various expressions: printed paper, images, and advertising. Let us all together engage in an examination of our consciences, and in a serene way: perhaps at times we have exaggerated, with a good purpose in mind, with a pietistic and sentimental communication aimed at calling public attention in an emotional way to the situation and condition of so many unfortunate people.

It is certainly the case that people are struck more by the suffering image of the person who is wounded by the disease of leprosy than by the organised efforts of science which are carried out in the anonymity and the silence of the laboratory in order to defeat leprosy. This is something which is normal; it is something which is human.

But unwittingly perhaps we have ended up by perpetuating the idea of an unavoidable reality which is more concerned with the field of charity than with the world of scientific research and human advance. It is true that many things are changing because of the joint efforts of a very large number of health care workers, associations, and missionaries who dedicate themselves to fighting leprosy and everything which is connected with it at the level of prejudice. But it is essential to continue with an educational endeavour aimed at cancelling the taboo which is at the base of an erroneous relationship with this malady. The provision of rigorous and correct information on the social context in which it develops, making people aware of the seriousness of certain situations, and this without any concessions to rhetoric – this is possible and is not something which is in contradiction with charity, indeed it grafts itself onto it as a natural complementary element.

I believe that the real challenge, in addition to that of treating and preventing this disease, is that of eliminating within today's culture and world of communications that sense of fear which still binds us as though in chains and which generates forms of exclusion.

Dr. CLAUDIO RAGAINI,
Journalist,
Italy.

The Pontifical Council
for Health Pastoral Care

The Pontifical Pastoral Institute
'Redemptor Hominis'

Study-Seminar 'The Sacraments in Pastoral Care in Health'

The Pontifical
Lateran University
2-3 June 2000

Introduction to the Deliberations

I would like to warmly thank the Lateran Pontifical University and in a special way its Magnificent Rector, H.E. Mons. Angelo Scola, for its generous – participation in the deliberations of this study-seminar on the subject of 'the sacraments in pastoral care in health'. This study-seminar has great importance for our Ministry, the Pontifical Council for Health Pastoral Care.

The subject of the sacraments in pastoral care in health will be discussed from the point of view of its cultural anthropological, fundamental anthropological, dogmatic theological, and pastoral theological aspects. This is a complete study which corresponds to one of the sectors of the programme of our Ministry - the sector of sanctification. And which corresponds to the specific task of directing the important aspects of our activities as a Ministry in line with the doctrine of the Magisterium, and which could be of great help for pastoral care in health throughout the world.

Indeed, recently we have witnessed a major change in pastoral care in health: many chaplains have begun to abandon the sacraments in favour of the presentation of the biblical word, or to provide psychological advice conceived as treatment which is also religious and which often emerges as something influenced by the evangelicals from an irenical or aconfessional point of view. We need to insist upon the Catholic doctrine of the sacraments and on its deeply therapeutic reality in the field of pastoral care in health.

The sacraments are the practical signs of the healing which Christ gives to us to carry out the mission that we receive to preach the Gospel and heal the sick. Health belongs to man in his wholeness, and in this wholeness one must not only pay attention to the physical or psychic, mental or social, aspects, but also and principally to the spiritual aspect. Spirituality in health sees the harmony and deep unity of man, and illness is to be seen in terms of a lack of harmony and unity. All the sacraments and especially the Eucharist and the anointing of the sick tend to give man this harmony, ensuring thereby that the redemption of Christ reaches sick people. Temporal health is a part of eternal health, and it is obvious that in this sense it is not to be merely identified with an absence of illness but presents itself as a move towards human unity, towards its full harmony. The sacraments are the action of Christ which leads man to this abundant life.

One does not have before one a simple so-called religious therapy in which external examples are proposed which should be imitated so that the illness can be borne more easily, even though this example is the example of Christ. In speaking about the sacraments we do not have before us something which is external and remains outside patients but something which is linked to their deep being and is a part of them as a received internal force of health.

It is true that we must all avoid so-called ritualism and that in addition where this is possible a suitable catechesis must be engaged in with regard to the value and meaning of the sacrament before that sacrament is received, but this does not mean that we should deny the sacrament when such a catechesis is not possible.

Whatever the case, we hope that this study, which we are about to begin, will lead us to enlightenment and a more suitable practice with regard to the receiving of the sacraments in the field of health. We hope that this cultural study will open up new horizons towards the sick and the sacraments, that the approach of fundamental anthropology will really show us the bases upon which we must act, that the dogmatic theological approach will deepen our knowledge of the sacraments and lead us towards authentic wisdom concerning the richness of the sacraments in pastoral care in health, and that the pastoral theological approach will offer us practical pathways by which to act in this field which is so necessary for the work of our Ministry.

I would like to warmly thank all the very eminent and distinguished professors who will do us the honour of helping us to reflect upon this most important subject. We are sure that with their evident expertise they will lead us to the desired goal.

I would like to thank the Secretary of the Ministry, H.E. Mons. José Luis Redrado Marchite, and our Under-Secretary, Rev. Felice Ruffini, for the work that they have carried out in preparing this seminar. I thank Mons. Jean-Marie Mpendawatu for having co-ordinated the programme. I also thank Don Krzysztof Nykiel, the Official of our Ministry, for all his work in organising this seminar. My thanks also go to all those who at the Lateran University, in addition to its Magnificent Rector, H.E. Mons. Angelo Scola, have contributed to the celebration of this event, and especially to Rev. Mons. Sergio Lanza, the Dean of the Pastoral Institute 'Redemptor Hominis', with which we have promoted this seminar.

And I also thank very warmly all those assistants who through their active participation contribute to a greater illumination of sacramental pastoral care in the world of health and health care.

H.E.Mons. JAVIER LOZANO BARRAGÁN,
Archbishop-Bishop Emeritus of Zacatecas,
President of the Pontifical Council for Health Pastoral Care,
the Holy See

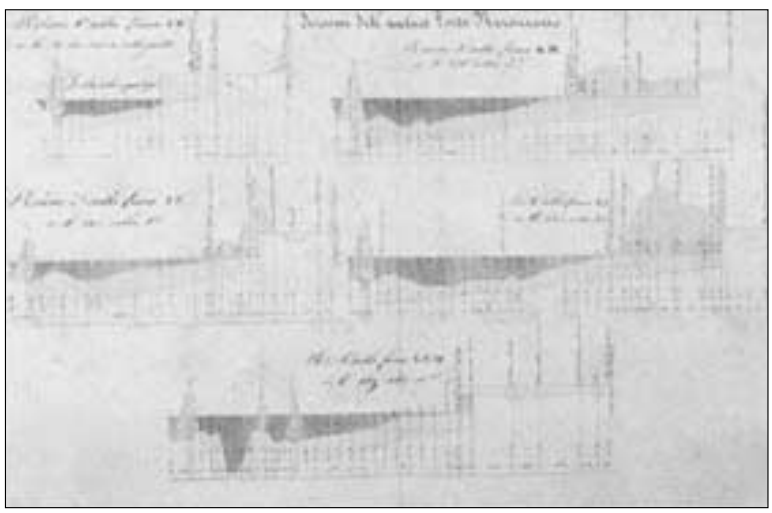
The Sacraments in Pastoral Care in Health

If we have faith, the sacraments are miracles. They renew our lives and all those things which surround our lives. They express nothing less than the concrete reality of salvation. To summarise: they have something to do with what is on a grand scale, much greater than health or the consolation which we so need when we fall ill. Taking the argument to extremes – and to remain within the subject of our encounter here today – we could even say that the sacraments are what really gives meaning to health and illness. But, as we know, today all this is increasingly taken less and less for granted both by medical doctors and by patients.

The culture of our age, our way of being and feeling, interacts only with difficulty with the sacramental dimension. I would say that it has almost dismissed its assumptions, enveloped as we are increasingly within relativistic, functionalistic, and immanentistic dimensions. It is, however, my opinion that we must not lose heart at the fact that the folly and the inhumanity of this envelopment are beginning to manifest themselves almost everywhere, and in a striking way precisely where we have to deal with illness. By this I certainly do not mean to diminish the dramatic character of the cultural situation in which we live. I merely wish to observe that with regard to 'pastoral care in health' it seems to me encouraging to see that the reasons which make it difficult are the same which make it increasingly necessary.

Ever since the world has existed, and however one wishes to interpret it, illness – especially when it is serious and perhaps afflicts innocent children – has always represented a sort of source of scandal, something that weakens even the strongest hearts which are most animated by faith. Notwithstanding this fact, we know how specifically faith is able to project it into a new light, to endow it even with the meaning of a 'positive' sense of sanctification. 'You are the powerful of the earth' – these are the beautiful and terrible words addressed by John Paul II (I do not remember where or when) to a group of terminally ill people in order to exhort them to pray. But how can we accept illness in a world which, having abandoned every idea of beyond this world salvation, seems by now only able to think about health?

There is something which is sinister and very real in the description that Albert Camus in the prologue of one of his most famous novels offers of the city of Oran, the city of the plague. It is a passage which seems to have been written to introduce our discussion: 'it is never pleasant to be ill but there are cities and countries which support you in illness, in which one can, after a certain fashion, let oneself go. A sick person needs tenderness, he likes to lean on somebody, and this is a very natural thing. But in Oran the excesses of the climate, the importance of the business which is carried out there, the insignificant environment, the speed of the sunset, and the kind of pleasures to be encountered, all these require good health'.[1]



You get into trouble, therefore, if you fall ill in Oran. You get into trouble if you fall ill in a world which seems programmed only for the goal of 'good health'. This is the first point around which I would like to organise my reflections in this paper.

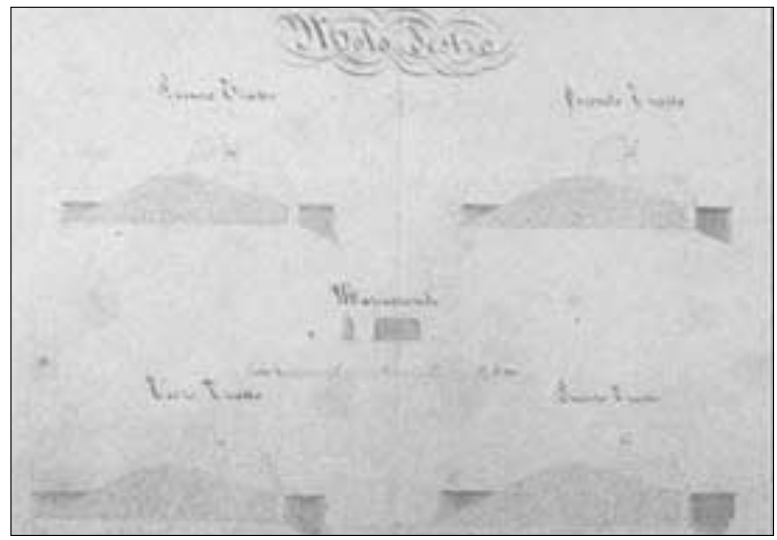
Among the many effects of modern secularisation we can without doubt list that progressive rise of health to a position where it is placed amongst the most important values. We need only look around us to understand that the 'importance of business', 'the insignificant environment', and the 'kind of pleasures' have gradually produced a kind of substitution of salvation by health. Dr. Rieux, the doctor of the plague of Camus, in a famous dialogue with another protagonist of the novel, the Jesuit father Panelaux, tells him clearly: 'the salvation of man is a phrase which is too high for me. I cannot see so far ahead. His health interests me, above all his health'.[2] But in reality it is also the case that most of the men of our time seem interested only in health. If in the Latin word '*salus*' there was implicit both the meaning of physical health, the health of the body, and the meaning of the health of the spirit, that is to say something which in a certain sense refers to salvation, today the two meanings have become separated to the point of a kind of alienation. All this, as is easy to perceive, has come about above all with consequences which damage salvation. If however we reflect well – and such could not otherwise be the case – this has come about above all with effects which damage the good of man, who,

by the simple fact of thinking only about health, has certainly not defeated illness and death. Quite the contrary. We fall ill and die because of an illness and a death which are increasingly without meaning and without hope.

'When you have health you have everything' our grandfathers declared. But they said it animated for the most part by the wise knowledge that it is not worthwhile worrying too much about the affairs of this world and neglecting thought about the things which really matter (we can accumulate all the riches and all possible and imaginable pleasures but nobody can ever guarantee us that this very night, for one reason or another, we will not be carried away from this life). Here the health which was invoked was something connected to '*salus*'. It also had within it the idea of salvation. It was both the health of the body and the health of the spirit. Today, however, when we say that health is everything we are thinking exclusively about the health of the body. We say this because we are convinced that without it our lives would not have meaning, rendered incapable as we would be of enjoying to the full its innumerable opportunities. In a few words, once health is lost, the health of the body that is to say, no hope is left. Everything has been lost. Hence the bewilderment which we encounter during our epoch in relation to illness and death (what is the real purpose, the latent purpose, of the very expensive national health service?), but perhaps also the increasing inability, especially on the part of young people, to give a really satisfying meaning to their lives.

To this nexus between bewilderment about death and the inability to live a meaningful life, Giacomo Leopardi called our attention in an almost prophetic way in an extraordinary passage from his work *Zibaldone*: 'And overall one can say that the ancients in living did not fear death, and the moderns, not living, fear it. And that the more the life of man is similar to dying the more death is feared and fled from, it is almost the case that we are frightened by that constant image which in our very lives we have of it and contemplate, and those effects, indeed that part, which although we are alive we experience. And *vice versa*'.[3]

Nobody, obviously enough, wants to deny the enormous advantages that the modern epoch has brought us, while little by little the spheres of 'salus' as the health of the body and the spheres of 'salus' as salvation have been differentiated. It seems however that the radical separation between these two spheres has meant that in the long term the sphere of salvation has become almost redundant with negative repercussions as well for our ability to exploit to the full the undeniable advantages of better health. I would like to explain myself better with regard to this point.



Speaking in Luhmannian terms, and without any nostalgia for the times when the medical doctor overlapped with the magical and mysterious figure of the wizard, it should be reasonably clear that today's medical science is concerned with the health of men and religion is concerned with their salvation. If, however, we look at the facts, we must agree that health has been endowed with 'ultimate' meanings and the medical doctor – a medical doctor who is increasingly specialised, increasingly inclined to look at the person of the patient and increasingly technically concentrated on the illness – has perhaps become despite himself the real bearer of these values. Thus we have on the one hand medicine and medical doctors of a highly technologicalised character (an effect of modern differentiation), and on the other an increasingly large number of patients who go to the doctor as if he were a wizard of ancient times. In theory, obviously enough, nobody wants to confuse the medical system with the religious system but in fact health has become real salvation, illness real damnation, and the medical doctor the real priest.

The situation is without doubt paradoxical and has something to do, in my opinion, with the very nature of the phenomenon of differentiation. This is a phenomenon which, given its importance, deserves to be described, at least in general terms, especially in relation to its Luhmannian-systemic variant. What is for Luhmann a differentiated and complex society? It is a society which has lost, precisely because of this reason of its complexity, its very centre. There is no longer anything, no religious, ethical or political value which can represent the reason for being of a society. There merely exist a large number of problems (hence the complexity) which can be solved only by selecting them, by specialising that is to say a suitable social system (hence the differentiation) which can solve them. Each social system has its own function of reducing them. The political system has its rules, its codes, its functions, in the same way as the economic system, the religious system, and the health system have. Only difficulties emerge if they are confused. No system, in fact, can interfere with another given that the system is by its nature

closed within itself, 'auto-referential', capable that is to say of seeing only the problems for which it was created. For new problems there will be new systems, in a sort of continuous and unstoppable process of differentiation.

As I have written elsewhere,[4] however much the systemic theory is false we cannot, unfortunately, exclude it becoming 'true' at the level of facts, that is to say that today's social realities rends to really take on the form that Luhmann attributes to them. Whatever the case may be, we have before us a dynamic which, in my opinion, becomes more perverse the more it touches upon those social systems in which the humanity of man is most involved. If indeed it is possible to think that urban traffic can be organised in a systemic form, the same cannot be said with regard to hospitals and schools, to give just two examples. And yet such is the case. In order to deal with the complexity produced by its constant differentiation, contemporary society seems to really support the functional aspects of its various partial systems without much concern for what we could call the 'human' aspects. Expressed in highly summarising terms, however much his autonomy and liberty may be invoked, the individual seems no longer to constitute the centre or the reason for being of society, and is rather relegated to the margins or if one prefers to the 'spheres' of the above mentioned social systems. It is increasingly taken for granted, to give just one example, that the market, science, politics, the mass media, and the health system all have their specific logics, their functional codes, with which nobody is allowed to interfere. This is why man has no other choice than to adapt himself (if he can, otherwise a bad end awaits him). With the words of Niklas Luhmann, the author who has theorised with the greatest radicality the functionalist position, we could also say that 'man is no longer the yardstick of society'.[5] Here we encounter, in summarised form, the meaning which from certain points of view is most disturbing about what is an increasingly functionalised society.

If we look at the health system I do not believe that it is difficult to see how greatly it is permeated by this functionalist logic. Man seems really to be relegated to the 'sphere' of the system. Both the medical doctor and the patient become the poles of an apparatus that functions more or less well in line with whether it manages to depart from the 'humanity' of both. During the 1950s Karl Jaspers was already placing emphasis on concern with certain 'dangers of scientific medicine'. As he wrote: 'between the medical doctor and the patient are placed clinics, insurance, research laboratories. A world arises which makes possible a form of medicine which has greatly grown in terms of its effectiveness but which contrasts with the very condition of the medical doctor. The medical doctors become functions: general practitioners, specialist doctors, hospital doctors, specialised technicians, laboratory doctors, and radiologists'.[6] As for the patients, they are increasingly reduced to being the mere 'customers' of a 'company' (the ASL) which treats them in an increasingly impersonal way in line with standardised procedures (the famous protocols) which are applied in a mechanical way to the illness and not to the sick person. Thus it happens that what is gained in terms of effectiveness, which is certainly obtained from such a health system, is paid for in terms of 'humanity' because of the ways in which this system functions. 'Great successes at the level of treatment', continued Jaspers, 'are achieved every day in relation to sick people but, and this is an amazing thing, there is a growing dissatisfaction, both amongst the doctors and amongst the patients'.[7]

An epoch such as ours, which is increasingly technologicalised and functionalised, takes away with one hand what it manages to give with another. It certainly offers great opportunities to tackle and heal illnesses which until yesterday killed people without even being known about but at the same time it leads to an exponential increase in our needs, our hopes for health, and this to the point of transforming illness into an unbearable scandal. In varying ways we live today with the illusion that everything is possible in technical terms. Even when technological and scientific development provokes concern, in reality we tend to think that science and technology will nonetheless provide a remedy to our problems. This increases the assumption that the things of this world depend above else on us, on our power. It exasperates our wish to be happy on this earth; it takes away the ground from under our feet, where there are the things of heaven. Health, from this point of view, is no longer a gift, the most valuable gift that God can make to men, but becomes instead a 'right' to be claimed at any cost. You must get better. If you do not get better it is the doctors' fault. The situation is rather like that with earthquakes: the first thing we do is to get indignant at an event which we perhaps think is unjust, but we then hunt down those who have not built the houses in line with anti-seismic criteria.

With a rather pointed witty remark, we could say that our mentality is producing a sort of 're-enchantment' of the world upon a technological basis. It is no accident that precisely today, in the so-called advanced Western societies, we are encountering a great revival of magical rites and practices. As Max Scheler well perceived at an instinctual level, magic should not be classified amongst the forms of metaphysical or religious knowledge but amongst the forms of technological knowledge. Indeed, if we want a clear idea of what this practice entails, we go to the magician or wizard above all else because it is unbearable to recognise that, for example, nothing can be done about a certain illness. It is unbearable to us not to know beforehand if this or that concern will turn out well, if we will fail or pass an exam, if we will manage or otherwise to win the heart of that beautiful girl etc. etc. What does not depend on us (that is to say most of the decisive matters of our lives) is increasingly difficult to accept. Thus, by a kind of power mania, we are losing the meaning of reality, the meaning of our real good.

In a socio-cultural context

such as the one to which reference has just been made, and returning to the chief argument of this paper, you do not need much to understand how difficult it is to speak about the sacraments. The sacraments indeed, when they are not expressly rejected, run the risk of being received in a magical and instrumental way, with thought being directed primarily to 'health' and not to 'salvation'. Despite this fact, as I observed at the beginning of this paper, we should not lose heart. We all know that behind the fleeting wish for health and happiness, something that is typical of our epoch, there is for the most part the frustration of a culture impregnated massively at all levels with 'artifices', 'artefacts', and 'cunning', which has gradually lost its sense of reality. But as Aristotle knew, happiness 'is a certain way of living'. Health itself, as Hans-Georg Gadamer recognised among others, is not a 'product' of the medical doctor but 'what is natural in itself'.[8] Whatever the case, one does not take a pill in order to be happy, not does one choose to fall ill or to die. We can only hope that we will be happy despite illness and death. This is the authentic, albeit from certain points of view dramatic, realism of our faith. At this level, at the level of faith, the sacraments acquire a divine reality. They certainly become an intervention of God in the human sphere in order to save man from illness and death. But because they too are based upon the cross they force us not only to never lose sight of suffering but to become so 'mad' as to accept them.

Those who have looked after a sick person at least once know to what extent faith can provide serenity and courage in facing up to illness and how much all this has real beneficial repercussions, at a physical level as well. I believe however that the acceptance of what I referred to above is the greatest miracle which faith can perform in a world such as ours, a miracle which contemporary man greatly needs and to which, perhaps, he is far more often open than is believed.

'All men are mortal, Socrates is a man, Socrates is mortal'. Ivan Ilic, the famous protagonist of the tale by Tolstoy, reflected upon this syllogism, obsessed as he was by imminently felt death. 'But I am not Socrates!!!' the same figure seemed to shout out, almost to flee at any cost from the hard reality which faced him. Yet we should observe that this comment is both beautiful and emblematic if we think about the death of Socrates as related by Plato's *Phedone*. Ivan Ilic, as a good modern bourgeois, after relying so much on an ordered life without breakages, of an almost 'scientific' character, when faced with death no longer accepts even the logic of the most elementary syllogism. Socrates is about to drink the hemlock and is still so loyal to reality as to enjoin his disciples not to forget 'the debt of a chicken to Asclepios'.

I know that the sacraments are much more. But I would be satisfied if in an evasive, fleeting and cruel world such as our own clearly is, they helped us to bear illness and death as Socrates bore them – as men.

Prof. SERGIO BELARDINELLI,
Professor of Philosophical Anthropology,
the University of Bologna,
the 'John Paul II' Institute of the Pontifical Lateran University.

Notes

[1] A.CAMUS, *Le Peste*, in by the same author, *Opere* (Classici Bompiani, Milan, 1974), Vol. I, p. 133.
[2] *Ibid*., p. 306.
[3] G.LEOPARDI, *Zibaldone*, 3031.
[4] Cf. S.BELARDINELLI, *Una Sociologia senza Qualità. Saggi su Luhmann* (Angeli, Milan, 1993).
[5] N.LUHMANN, *Sistemi Sociali* (Il Mulino, 1990), p. 354.
[6] K.JASPERS, *Il Medico nell'Era della Tecnica (Raffaello Editore,* Milan, 1995), p. 48.
[7] *Ibid*., p. 45.
[8] Cf H.G.GADAMER, *Dove si Nasconde la Salute* (Raffaello Cortina Editore, Milan, 1994), p. 42.

The Sacraments: Anthropological Approaches

Introduction

In this paper of an anthropological character we will try to engage in a sort of outgoing and incoming:

– on the one hand, the human condition, that is to say its nature and its insertion in the history of salvation, illuminates the mystery of the sacraments, throwing light upon their co-existence and their meaning:

– on the other, the sacraments, both with regard to their internal structure and their mutual relationships, illuminate the mystery of man and bring out the dimensions of his life which are reached by divine grace.

This double approach assumes that the major facts of the doctrine of the sacraments are known, as well as the attempts which have been undertaken recently to re-insert the sacraments into the economy of the redemptive incarnation and into the ecclesial body. On these bases, we will try to place these facts in relation to the mystery of man and thereby to enrich our understanding of it.

For this reason we will begin with a pastoral difficulty which has become really quite widespread in our Western countries over recent decades – the phenomenon of the regression of religious practice. Such a reality, indeed, would suggest that the sacraments are of little interest to contemporary man. Is this really the case? Can we grasp what this reveals in a negative sense about the relationship between man and the sacraments?

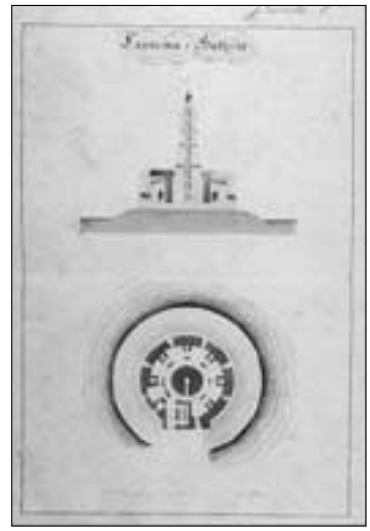
Whi is a 'Non-Practicing Catholic'?

For many baptised people contacts with the Church take

place only at the times of the great moments of family existence – chiefly birth, the catechism of children until the threshold of adolescence, marriage, and death. To these should be added the festivals of 'all saints', of Christmas, and of Easter. It is precisely at these times that the priest hears the famous declaration: 'Father, I am Catholic, but I am not a practicing Catholic'. This declaration is at times surrounded by a number of other observations: 'this does not prevent me from trying to do good, or to pray on my own; it is better to have inner sincerity than outward and hypocritical practice, etc.' When a deeper dialogue is possible it is realised that the problems are to be found at completely another level. The phrase 'a non-practicing Catholic' is intended to make us believe that the person is still essentially Catholic but that his attendance at external Christian actions has merely diminished somewhat. But in fact does not non-practice perhaps reveal rather a substantial abandonment of faith itself? What does a 'non-practicing Catholic' believe in, and live out, we might ask, at a religious level? Without wanting to judge people case by case, the experience of pastoral dialogue enables us to detect a certain number of basic tendencies.

1. The non-practicing Catholic sees his or her life in general from two points of view: the inner level, that is to say sincerity (which can include a certain life of individual prayer), and the external level, that is to say concern with a minimal moral life (thou shalt not kill, being generous, etc.) For the non-practicing Catholic such indeed is the essence of the Christian life. What is primarily absent here is the explicit exercise of the theological life. It is certainly the case that it is not necessarily absent, especially if the individual concerned has maintained a certain life of prayer (something which is not unfortunately always the case). But what remains tends to be reduced to an intimate individual sphere and no longer finds space by which to express itself outwardly. The personal dynamic of the theological action of the interior towards the exterior is wounded, the expressiveness of the filial heart in the flesh and the world. It is certainly the case that interior sincerity still finds expression in a certain concern with leading a moral life but this concern is not specifically Christian (it can be found both in Buddhists and agnostics, and indeed in atheists). If there is still faith in God or in Christ it is no longer expressed in actions or specific and explicit words – this is true with regard to the sacraments but also in relation to public and visible prayer, in being concerned with expressing one's own faith around one, or in daily life in the wish to act not only honestly but also out of explicit love for Christ.

2. This fracture in the dynamic of exteriorisation takes on the dynamic of the movement of spiritual interiorisation. This means the ability to recognise



and to internally integrate the presence and the initiatives of Christ in the same way as they present themselves in me in practical externality;

– in the sacraments which have a visible, hearable and palpable character, and which take place in my personal and social history;

– more globally in ecclesial life, that is to say in belonging to a community which means and realises belonging to divine communion;

– and also in every type of event, call and encounter through which Christ speaks and acts: for example, this poor person on my path, this opportunity to serve my brothers and sisters, my profession, this endured offence which likens me to the crucified Christ.

Those who do not practice in general have a very attenuated sense of this living presence of Christ and his divine friendship to be found at the heart of the events of their practical lives. As for what remains of their sacramental lives, a shadowy sacredness often takes the place of living faith in Christ which works through the contemporary power of his resurrection. Membership of the Church tends to become reduced to a not very attractive legal formality. The tissue of daily life, family life, work, society or being a neighbour no longer seems, within the context of freedom, as the practical place for the expression and the realisation of the choice and call of God. It tends to become reduced to alternating between stressing social constrictions and compulsive distractions. The need for God or the sacred is no longer manifested in certain precise opportunities.

3. All of the spontaneous representation of the real and of life is thereby touched upon. In a context of non-religious practice God loses the concrete, historical and incarnated countenance that He has in Jesus Christ and his Church, and He becomes the object of a shadowy belief, 'a power above us'. Every act of man no longer concerns *hic e nunc* his love for Christ: what is needed is a positive overall moral balance. This is not Christianity but deism. In fundamental terms it is the mystery of the redemptive incarnation which is lost from sight. Although it is historically true that the Church and the sacraments are the valuable gifts which Christ paid for on our behalf with his own life, I cannot therefore withdraw myself from them of my own free will without wounding him in his love for me, and without wounding his Church because of my absence: in the sacramental *hic et nunc*, indeed, this love is offered to me and it has that much more burning presence because of Christ that my mission and my eternity keep it for ever in my heart and are at work in the present. If I am indifferent to this reality (perhaps without this being my fault) this means that I have not perceived the concrete reality of this mystery which,

however, constitutes the specific centre, indeed the beating heart, of the Christian faith.

4. Connected with the mystery of the incarnation, what is at play in this area is the perception of the concrete reality and the otherness of the Person and the love of Christ which is so much greater than our own. To the non-practicing Catholic it appears that the perception of his moral good will is enough. Compared to the very strong love of Christ towards him, it is here at a very low level indeed, and is almost disappointing. As St. Augustine says: 'the measure of love is to love without measure'. This measure cannot be reached by man if he does not receive it from He who 'still loved those who were his own, whom he was leaving in the world, and he would give them the utmost proof of his love'(Jn 13:1). At the same time the non-practicing Catholic has no interest in his religious actions other than with reference to 'what they bring him', something which is understood from a subjective and immediate point of view. He does not take into consideration whether these actions are concretely sensitive to the Heart of Christ, or if they bring something in an objective sense to the Church and the world. It is certainly true that the approach of non-practicing Catholics is not insignificant – if 95% of young people who receive catechesis distance themselves from religious practice because in their view it does not bring them anything, we have to conclude at the least that in a number of years of catechesis we have not been able to give them in an existential sense what the sacraments actually bring them.

Here there is a real pastoral question. When it becomes excluding, however, this perception of the sacraments reduces them at times to a psychological gratification, and thus to disappointment and to withdrawal when this gratification is not present. Here there is probably a logic of immediacy which is generated by a part of the environment of consumerism in which we find ourselves. It impedes seeing Christ as transcendent in relation to my desires. This very logic weakens the whole field of interpersonal relations – it tends to reduce the other person to the status of a mere instrument of egocentric satisfaction. In contrast, the material and ecclesial objectivity of the sacrament which I must receive as it is given to men manifests a grace of which Christ himself, and not my feelings, is the origin and the measure.

This fact is very clear in the example of the sacrament of forgiveness. My sins are in historical terms participants in the crucifiction of Christ, and I cannot reduce forgiveness to a gratification or to a fact to which I have a right through uttering a small prayer. In relation to every person who is offended by me, but even more in relation to Christ, to ask forgiveness pre-supposes a moment of effective vulnerability. It shows that my sin makes me unworthy of what I am asking for, and that forgiveness is everything, the total unmerited gift of Christ 'who loved me and gave himself for me' (Gal 2:20). It also shows that he, and not me, is the judge of the interior arrangements which enable me to receive his forgiveness. Because it integrates the confessions with the minister sent by Christ, the structures of the sacrament of forgiveness permits this vulnerability, this glance of truth onto my life received from the outside, and the unexpected joy of the unmerited gift which has been received. All the attempts to by-pass this moment are in this respect insufficient, both in objective and in subjective terms.

Let us now conclude this series of observations. What does religious non-practice reveal in negative terms from an anthropological point of view? It brings out how the sacraments are for the person the important factors of spiritual balance in the relationship with God and with Christ. The objective character of the sacraments allows the dynamic balancing between the interior and exterior worlds of the person who receives them. This balancing has its fundamental reference point in the mystery of the incarnation – the sacrament is the event of salvation in the history of the person, an initiative of Christ who actualises the central event of salvation, that is to say his death and his resurrection for all of us and each one of us. The context of this balancing is found in ecclesial mediation: the sacrament manifests itself not only as individual grace but as grace through the Church and for the Church, which is the concrete place of communion. Where the practice of the sacraments disappears one cannot be surprised at the undoing of this balancing between a closed subjectivity and an insignificant objectivity, between an 'intimist' individuality and a Church which has become extraneous, between a secularised historicity and an abstract God.

The Sacraments and the Sense of the Sacred

We have so far not addressed ourselves to a point which we should now look at more closely. The regression of religious non-practice has often been interpreted only within the context of secularisation: when sacramental life disappears only profane life remains. Now it is increasingly evident that such is not the case, at least in the long term. For some years reference has been made to the 'return of the religious'. Only our lack of vital contact with real culture can explain the fact that we did not realise this earlier – spiritism became fashionable at the end of the nineteenth century; from the 1960s onwards orientalism invaded the world of songs (the Beatles amongst others are a good example of this); and the spread of esoteric and parapsychological themes was already very advanced by the 1970s (to become aware of this it would have been enough during these periods to look at the bookshelves of libraries catering to a large reading public). These phenomena have become massive in scale. In weakening the visible reference points of Christian actions, secularisation creates only temporarily a religious vacuum – this emptiness is very quickly filled by profane idols (progress, Communism, science, fashion, youth, and health etc.), and when faced with their inability to make man happy these last are followed by explicitly religious idols. Today the problem is not that of making a rationalistic world accept

the fact that Christian miracles exist – it is rather to show that they are not a particular case of what is strange in general (mental powers, UFOs, etc.).

What is this 'sacred' which takes the place of the 'Christian sacred' of which the sacraments are the centre? In overall terms, it corresponds to a stepping back from the personal countenance of God: one has less to do with 'somebody' than with 'something sacred', with an anonymous and multiform mystery. There then follows a search for experiences of the sacred which no longer have the form of a personal encounter with God but with an immersion in a great 'everything', or with a handling of energies of a

magical kind. In New Age 'channelling' there is still an attempt to enter into contact with 'spiritual entities' but it is not important who or what they are – interest is found in experiences which introduce us, in results or in powers, to that which through them it is possible to gain access. After all, the questions 'who is God' or 'who am I' acquire diminishing importance the more people are understood as bundles of energies which should be harmonised, and it is not to be excluded that they can fuse, indeed divide themselves, into 'sub-personalities'. This way of seeing things also implies a stepping back from a sense of freedom, and an oscillation between a feeling of being subject to flows of time and attempts to dominate them and manipulate them ('gratuities'). It should be added, lastly, that this sense of the sacred also corresponds to a strong return to symbolic thought in opposition to conceptual and rational thought. Whether cosmic or anthropological in character, all symbolic experiences become immediate 'hierophanies', that is to say possibilities by which to engage in direct communion with the divine. We are thus here in full-blown pantheism – a divine All of which every man is supposed to be only one aspect, a Totality ('whole') whose particular element can enable us in a certain sense to enter into resonance with symbolic experience.

Here one can recognise the figure of the first sin: the attempt to take possession immediately of the absolute by reducing it to something (the fruit near to hand), an attempt which is rewarded with a reduction of oneself and that very state (men become things to each other or things jostled by the forces which are above them). Now, this figure of sin is understandable only in relationship to the original grace which repudiates it – 'the human being in the image of God'. Now, the 'image' in its biblical sense is a reality which is almost sacramental: it is not only the 'representation' of something but after a certain fashion its effective presence (this explains the Old Testament prohibition with regard to making images of God). If this is the original condition of man, then every action of his becomes an effective sign of the loving action of God – the sexual polarity is an effective sign of the presence of the Creator towards his creature: called 'to grow and multiply', man and woman become, through the very gift of human life, ministers of the divine life of their children. And the relationship which they engage in with the Creation which must be 'filled and governed' is called to be the place of the gift of God. The 'sense of the sacred' which is symbolically inherent in the great anthropological events and in the relationship with the creation is interpreted as that which remains, after the sin, of a sacramental order which should have been co-extensive with acting humanity. What remains is a set of human experiences which suggest and recall the divine but which no longer communicate it. And in a context where man searches blamelessly for the divine there remain these failed attempts to take possession of it, and these are characteristics of both ancient and new paganism.

One cannot attribute to the sacraments the same kind of 'sacredness' as that which we are currently witnessing as being on the increase. The sacraments situate us as people before a personal God, and the fundamental grace which they give us is not a fusional experience of the divine but a real and distinct person, namely Jesus Christ. However, if what we have just observed is accurate then their relationship with the human sense of the sacred should not be conceived solely in terms of opposition. For the non-practicing Catholic the sacramental questions appear first and foremost as wishes for a sacralisation of the great events of his or her existence. In other terms, the absence of religious practice has progressively led their sense of the sacred from its personal and relational form in Jesus Christ to its pagan form which is co-extensive with the life of man, and weighed down more or less with immediacy and anonymity. However, sin wounds nature but does not destroy it, and the grace of Christ does not deny it but heals it and raises it up – as a 'new birth', baptism engages in an authentic relationship with human birth; as 'Christian maturity' confirmation has a real link (to be made clear) with human maturity. This means that the questions posed to the Church with regard to the sacralisation of the great events of life remain humanly legitimate. And in the economy of grace which belongs to us only the Christian sacraments correspond to it adequately, and even transcend this answer.

Far from being something which should be despised, the 'sense of the sacred' which these sacramental questions manifest is thus to be taken seriously: it is the place of a religious wish which on the one hand is legitimate and on the other, if it is not evangelised, will return to pagan forms which are naturally derived from the first sin. The whole of the challenge of the parish ministry is to be found here. We cannot be satisfied with unilateral solutions: in sacramentalising them system-

atically, the sacraments are reduced to what is sacred in a pagan sense, but in rejecting the sacraments out of a purist opposition to what is sacred in a pagan sense one commits an error against man, and against the mystery of the incarnation which renders man divine without denying him but by healing him and taking him upon itself. The key to this challenge is called 'new evangelisation' – in this case it involves welcoming the sacramental questions as they are, that is to say in their initial pagan state in order to make of them a place for a vigorous proclaiming of the salvation which is only to be found in Christ 'because there is no other name in heaven or on earth by which we can be saved'.

Conclusion

A short observation to conclude this paper on the special context in which pastoral care in health represents is required. A certain number of anthropological realities acquire a particular weight – suffering and at times the prospect of death, the questions about blameworthiness and sin (Why him? Why me? The question of AIDS), but also about salvation (What comes afterwards?) And this without taking into consideration the special world in which these questions resound around the staff who are engaged in providing care and treatment. On the one hand, these are human experiences which place man in front of his radical powerlessness to save himself, and no place seems more suited than that of the heaviest human crosses if we want to proclaim the victorious Cross of Christ. On the other hand, it is also a field which the 'New Age' neo-paganism seeks to occupy by proposing, for example, psycho-spiritual therapies, or by accompanying the dying with a view to achieving a 'soft' death. And I have not referred to the practices of certain companies of undertakers which, with a view to achieving a more attractive service for their customers, seek to obtain ministers of worship who are used almost as employees in order to by-pass the parishes (this phenomenon is very advanced in the United States of America and is beginning to appear in France). These are the elements which should be taken into consideration or which will be taken into consideration in the short or medium term. The question which we have seen raised in an acute way in the parishes is also transplanted into the context of pastoral care in health – what in concrete terms will the relationship which we have sought to identify between sacramental pastoral care and the urgent need to evangelise or to re-evangelise (I am thinking here of the sick, families, and the staff engaged in care and treatment) actually mean and involve?

In this context the sacraments which are most immediately involved are those which concern the sick, forgiveness, the Eucharist, holy orders (the presence and role of priests and deacons), and at times baptism when death threatens. What are the means available to us by which to express in a clearer fashion what they are? Events of salvation embodied in human suffering, actualisations of the Cross and the resurrection, the passing near of Jesus Christ in Person, an ecclesial event? Similar questions I entrust to your discussions, which will now follow. Thank you very much.

Prof. DENIS BIJU-DUVAL,
Professor of Special Pastoral Theology,
the 'Redemptor Hominis' Pastoral Institute,
the Lateran University.

A Sacrament for Suffering. Faith in God and Hope of Life

The ritual action of sacraments is that special way of acting of the Church thanks to which she turns to man so that he, opening himself to God who saves, responds to the divine initiative and can thus believe.[1] Man is affected by sacraments in an existential situation which is in all cases concretely qualified, in such a way as to require him to organise his answer of faith within a situation of life which is well determined. The decision of faith does not represent a choice which takes place separately from the path undertaken by existence and is thereby abstracted from time and space. The divine truth, to which man corresponds in his approach of faith, possesses in itself a dimension of universality but without thereby being identified with an abstract principle or even less with a generic element. Divine truth is extended to all men with the invitation for each and every one of them to implement a taking of a position which is justified in the light of truth, that of God, which, far from eliminating the singularity of each and every person, knows how to effectively motivate and steward him. By this route divine truth is destined for man when man decides on his own, and the way, which allows each and every person to be conformed to the truth, is a way which is in every instance special. And it is precisely to that special experience, which is defined by the condition of illness-(death) and of suffering, that the Church has paid full attention throughout her whole history, with a continuity which in the light of research into the phenomenon of history appears more than evident.[2]

Beginning with her early stages the Church has thus shown that she takes seriously

the risk and the dangers which a situation of suffering bears in relation to the fulfilment to which man is destined because of the creation. From the beginning of the history of the Christian community care for those who are sick has been expressed through an action which is known and which is clear in its essential aspects, even though, at the present state of inquiry, it is not always fully known at a detailed level. Its end has been the salvation of the person who is subject to suffering. The invocation of the community, completely certain of the power of the Lord

because comforted by what it had been able to see in the 'reawakening' and liberation from death on the cross, turns to Him in order that He can benevolently answer the prayer of faith. The action of the community reveals in a totally transparent way the continuity which must subsist between the task, to which the community of Christian dedicates itself, and the mission, of which Jesus was the protagonist, in a completely unique way. The action is a part of the witness of the community which reaffirms during the course of the events of humanity what Jesus Christ committed himself to achieving once and for all to the benefit of men (cf. Mk 6:13 and 16, 17-18). In the carrying out of this task it is the whole community which must feel involved but in order for the carrying out and the meaning of the shared task to be consistent with the original and founding moment of the faith, the 'presbyter' has to perform a role which belongs to him and which he cannot therefore delegate (James 5:14-16).

The presence of the 'presbyter' is the sign and at the same time the guarantee of the quality that the witness of the community of Christians must possess in order to be at one with what Jesus made appear through the economy of his activity. In the personal history of Jesus Christ there is indeed the last 'time' of the history which is to appear within the history of humanity, placing in the heart itself of history the dynamism which animates it. The concern demonstrated by the community for the sick person sought to be, and was in factual terms, the expression of the full association of Christians with what Jesus had realised with his moments of healing and miracles. The episodes of healing made their appearance in the narrative of the New Testament in a measure undoubtedly more abundant than is the case with the Old Testament.[3] In the Old Testament only three accounts are given, which are perfectly detailed, of miraculous healings in instances of illness: the event of the serpent of bronze in the desert (Num 21:9); the healing of Naaman, the head of the army of the king of Aram (2 Kings 5:10-14); and the healing of Herezekiah the son of Acaz the king of Judah (2 Kings 20:1-11). The more than evident increase in the number of miracles of healing is wanted by the New Testament in order to the place the value of the definitive nature of the event of Jesus Christ in a suitable light. In healing is recognised the gift with which the coming of the final time is accompanied, that grace by which God introduces the irreversible completion of the history of men.

The completion, while it works to cover man with divine benefits, also involves the judgement of total condemnation on those who directly opposed the success of man, and in challenging it obtained only threats and dangers for man. The definitive work of God is the same that Jesus lived and in the name of which he spoke with a level of authority which immediately appeared different to that of other teachers. This work of God found its actualisation and obtained its visibility in the answer that was given to it by man, who is invited to believe, bringing thereby fruit against every hope through the fact that God himself came to visit him in order to achieve a completion which does not disappoint.[4] The seal of the answer which is given by man has already been presented and given to him because of the cross of Christ since Jesus Christ himself 'has to' offer all of himself so that the salvation which God knows how to give to him who remains faithful, faithful to the end, may manifest itself. It is thus of extreme importance that Jesus declared with his words and made evident through his style of life how the beatitude of God was already present and working amongst men. What he moves to specify is the form in which, uniquely, 'happiness' can be the 'completion' of man and what was, as a result, the motivation which should inspire him with a view to choosing between real and false happiness, between having life and losing it irremediably (Mt 5: 3-12). In this way Jesus places himself against that belief, which was certainly more common and widespread, which believed that it could see in happiness the task to which the action of man must be directed.

Happiness, more than being placed at the end of the action, and thus more than being the consequence which in acting man would be able to reach, is in reality what comes to him through being given because it is at the origins of the actions which must be carried out. The only possibility for happiness, in which the authentic completion of man must be perceived, does not define that for which and towards which man works, but rather the impetus that supports and the factor which animates the work of man. The evangelical promise introduces by this the news of a reward which is certain for all those who live in the freedom of the faith, since faith, in not springing from itself, can nourish interest in others. The gift received is the root of the service destined for all people because in the service which is given there is no reason for contradiction or an impediment to the completion of ourselves. The

man of faith encounters the Lord in the needs of the material body of this world and with reference to how the encounter in matter is structured will be pronounced the judgement on the behaviour which has been engaged in (Mt 25:35-6). For this reason, God does not annul the wish for happiness and for life felt by man but ensures that the wish becomes fully correspondent to the truth of living. In this sense, even if only in this sense, the suffering of illness can be said to be a proof, to the extent to which it imposes on man the process of deciding in relation to life and to that meaning for which – that is to say in the specific nature of his personal being – he is not lost.

The sacramental rite is thus something which allows the sick man to actualise his decision in relation to existence since the property of the ritual act of the Church consists in bringing into play what the God of Jesus guarantees and makes possible to the total benefit of each and every person. That one is dealing here with an authentic decision which must be taken, and not a mere putting off of things which leaves to one side the possible elements responsible for the presence of evil, leaves however the state of things unchanged in an overall sense. This is also demonstrated by the suggestion that the philosopher Boetius makes in relation to the question of evil and guilt. As a prisoner and waiting to be executed he insists on declaring: "if God exists where does evil and impiety come from. And where does good come from, if He does not exist?" The only formula which can seek to identify the right place for the question of evil thus takes on the configuration of the question to which one responds only on the condition that one is exposed to it in first person. In the answer which is always and in all cases personal, in line with what Boetius emphasised, it is God Himself who is called directly into question. The appeal to someone else, who is not to be identified with God, would transform the role of evil present within suffering and blame into something which is clearly insignificant. The process underway in relation to evil must be carried to God, and to what are the contents of the divine will in relation to man as he is in the concreteness of his daily life.

Indeed, an alternative would seem to arise between divine goodness and divine power: if God is good why does He not direct himself towards warding off evil and if He is powerful why does He then tolerate evil and the influence of evil on man and the world?[5] The wickedness of evil, in the judgement of man, reaches its most evident expression when misfortune hits the 'innocent person', and the 'innocent' child, in a particular way, becomes a victim of it. The extension of the threat of evil is in this way without confines – not only because evil comes to strike suddenly but above all because it does not display any respect at all for anybody or even has some attenuating approach in relation to anybody. In the case of the child, man seems deprived of the very possibility of words and action through which he can at least distance himself from evil, pointing out the level of being outside in relation to which the wish for life exists and proposes. In this regard, and thus with respect to the clear certainty of the clearly destructive profile of evil, the most critical voice

which is raised against the overbearance and the weight of evil which can in no way be by-passed is that to be found in the texts of Holy Scripture. The Bible does not envisage presenting who God is and what His action of redemption involves by seeking to place them in safe refuge against the complaints of the suffering person.[6] I am referring here to the Book of Psalms which from a completely exclusive approach, but thanks to which we come to re-read the entire message of the revelation of Scripture, relates the complaints of he who is subject to suffering.

In the Book of Job, what myths have tried to repeatedly minimise, that is to say the need to begin with the divinity the discussion about evil, is proposed as an inevitable question, when there is not an attempt to banalise or undervalue the suffering of man. Job is neither calm nor resigned and for this reason he does not withdraw himself from probing what is usually maintained by other people and which his friends are ready to recall, making it have the value of a shared opinion. What is interesting in the account of Job is the particular form of 'submission' which the person of the text reaches and because of which, although he does not abandon raising his protest to God, he does not, however, come to a denial of God. In other words, the accusation and the protest of Job are not placed beyond the horizon of faith but it is precisely within faith that an attempt is made to reach a clarification by which to find once again and understand in a more pertinent way that in which he believes. This same objective is to be observed working in the formula of the psalm which, according to the judgement of certain scholars, has the same function as the '*ex voto*'. Prayer, indeed, formulates it once the goal of salvation of which the psalm speaks is reached. But in this way, in giving a strong relevance to the language of complaint, man, who prays with the psalm, clarifies how being subject to the impetus of evil cannot be considered by man as being 'natural'.

The spontaneous request is thus to put an end to all those forms of religion and to all those systems of reflection which want to present evil as the normal expression of the quality of finiteness of man and of the characteristic of incompleteness of the world in whose space man lives. Evil is not the mere sign of man's be-

ing in the world and the simple instrument by which his identity is ascertained. Evil is exactly that which attacks man by striking him in his entirety without confining itself to putting one of his features in difficulty or calling one profile into question, leaving his other components intact. This means that there is no necessary reason for the entering of evil into the scene of life of the individual or the world of men. There is no pertinent motivation for the corroboration of the declaration which maintains that evil must of necessity exist. Rather, the definition of evil is that which sees it as that which in itself must not in any way and for any end exist either inside or outside man.[7] In manifesting his counterposition to evil, the praying man of the psalms manifests at the same time the ultimate criterion of the assertions that prayer proposes, identifying it in the proud and resolute declaration of existence. That it is possible that man comes to have his name, that which belongs to him in a way which is naturally exclusive and specific to him – here is the essential fact of the prayer of the psalms raised in cases of suffering and evil.

Thus prayer, that is to say the special language of the human relationship with God, is fixed and defined in its subject matter and can be easily considered as the characteristic and root which are typical of evil and suffering. It is injustice which defines the central feature of the experience of evil and thus the feature with which such experience imposes itself on the perception, but in definitive terms on the resistance, of man. The complex of discourses which seek to decipher in a speculative approach the essence of evil, and the complex of projects which require instead a limitation of the power of negation in a practical perception, are soon in difficulty since they are largely insufficient in setting out a clarification in relation to what the human experience of evil brings into play. The affirmation, according to which men are indistinctly and constantly exposed to the overbearance of injustice, just as it does not dissolve the cause of pain so in the same way it does not know how to distance or even at the least to attenuate the level of difficulty and perplexity which the presence of evil itself introduces. The same reference to the quality of fragility, which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links men in a sole set and under the same genus, therefore leaves each and every man to go towards a destiny that is not up to the level of the fulfilment which man perceives that he bears and on which he makes walk his thought and his will. Evil is in itself and by itself everything that comes to interrupt the path of existence of man, making it so profoundly unintelligible as to force every person to remain distant from any possibility of refuge in a loneliness which for each and every one cannot but be the most complete loneliness.

In this regard, the inescapable question about the contemporary practice and thought of the Church concerns the way by which it renders feasible the encounter with the secularised experience of evil which is characteristic of this season of the contemporary epoch. Even the return into play of the sacred does not seem to change the prevalent tendency to secularisation but, rather, it flanks it, ending up by restating in substance its tendential line. The last part of the century which has just passed was – and not without a certain relevance – defined as a religious time but such a definition is awaiting a suitable evaluation and explanation beginning with the completely special meaning of the behaviour of faith. The question falls in particular on the capacity for cult of contemporary man because through the projects which he cultivates he ensures the prevalence of the figure of a humanity of facts deprived of traditions, the figure of a humanity which is both fluctuating and infertile. What is at stake is not man's capacity for cult taken in itself or rather considered in terms of its essential constituent, but the possibility of entering into the singular logic of the ritual symbols of faith. Now the sacramental rite of anointing must not be engaged in separately from he who precisely through this determined way, that of the action of the rite, expresses his will for salvation and offers man the criterion in the name of what he believes. The rite of the Church in distancing from evil places the approach of the Crucified One in the history of the Church in favour of the man of every time and place.

The Crucified One is he who distances the possible suspicion of man that there is a perverse and powerless God, to reveal, rather, a God, who although he is not responsible for evil nonetheless does not withdraw from the encounter that man engages in with evil. The ritual action of the Church allows each and every person to place his own condition as a suffering creature in the fire of this singular event, that of the Crucified One. The sacrament is not therefore the simple educational instrument which seeks to prepare the consciences of Christians so that their behaviour is up to the level of the requests made by the will of God. The sacramental action allows an effective taking part in the divine force which sets in motion that in which it itself becomes effective and manifests its power. The nature of this force remains concealed until man dedicates himself to it without compromises, allowing him to pass through it integrally. The statement 'do not be afraid', with which God accompanies his own manifestation to man, becomes fertile when in the 'now' of the decision man does not withdraw from it. The completely Christian paradox of a 'gain which is in itself only freely-given' of personal existence is what the

ritual action of the Church makes possible for each person. It is this which brings out to man the essential conditions for his unconditional adherence to the God of Jesus who listens without hesitation to those who invoke him in faith.

SERGIO UBBIALI
Professor of Dogmatic Theology at the Faculty of Theology of the University of Milan, Italy

Notes

[1] On the subject of the general question of sacraments see S.UBBIALI, 'La Riflessione Teologica sui Sacramenti in Epoca Moderna e Contemporanea', in *Celebrare il Mistero di Cristo, Manuale di Liturgi a Cura dell'Associazione Professori di Liturgia, Volume I, La Celebrazione: Introduzione alla Liturgia Cristiana* (= Biblioteca "Ephemerides Liturgica". "Subsidia" 73), C.L.V, (Edizioni Liturgiche, Rome, 1993), pp. 303-336; *Idem*, 'Il Sacramento Cristiano', in *Celebrare il Mistero di Cristo, Manuale di Liturgia, Volume II, La Celebrazione dei Sacramenti* (= Biblioteca "Ephemerides Liturgica". "subsidia" 88), C.L.V. (Edizioni Liturgiche, Rome, 1996), pp. 13-28; *Idem*, 'Il Sacramento e la Fede', *La Scuola Cattolica*, 127 (1999), pp. 313-314.

[2] For the results at which in the meantime theological inquiry arrived, giving full importance to the instruction that the teaching of Vatican Council II sought to offer on the question, see S.UBBIALI, 'La Teologia dell Unzione degli Infermi', *Teologia*, 10 (1985), pp. 229-271; ; *Idem*, 'Penitenza – Unzione degli Infermi', *La Scuola Cattolica*, 114 (1986), pp. 565-571; P.ADNÈS, *L'Onction des Malades. Histoire et Théologie* (Théologie Nouvelle) (Paris, FAC-Editions, 1994), translated into Italian by Mirella Magnati Fasiolo: *L'Unzione degli Infermi. Storia e Teologia* (Universo teologica. Dogmatica, 51) (Cinisello Balsamo, Milan, San Paolo, 1996). A.BÉRARD, *L'Onction des Malades. Sacrament de Guérison ou de Préparation à la Mort*, preface by Cardinal Paul Poupard, (Paris, Téqui, 1996). The dogmatic doctrine approved by the Council of Trent is outlined and explained by A.DUVAL, *Des Sacrements au Concile de Trente* (Rites e Symboles) (Paris, Cerf, 1985).

[3] G.CRESPY, *La Guérison per la Foi (Cahiers Théologiques, 30)* (Neuchatel, Delachaux & Niestleé, 1952).

[4] On the relationship between faith-hope and liturgy see P.PRIGENT *Apocalypse et Liturgie (Cahiers théologique, 52)* (Neichatel, Delachaux & Niestlé, 1964); U. VANI, *La struttura Letteraria dell'Apocalisse* (Aloisiana 8), (Rome, Herder, 1971); *Idem, Apocalisse. Una Assemblea Liturgica Interpreta la Storia* (Leggere Oggi la Bibbia LOC. 2, 15) (Brescia, Queriniana, 1982); P.PRIGENT, *L'Apocalypse de Saint Joan (Commentaire du Nouveau Testament, 14)*, (Neuchatel, Delachaux & Niestlé, 1981), Italian edition: *L'Apocalisse di S.Giovanni (Commenti Biblici)* (Rome, Borla, 1985).

[5] P.RICOEUR, *Le Mal. Un Defi à la Philosophie et à la Théologie* (Geneva, Labor et Fides, 1986), Italian edition: *Il Male. Una sfida alla Filosofia e alla Reologia*, Postfazione di Paolo DeBenedetti (Il Pellicano Rosso) (Brescia, Morcelliana, 1993); A.LACOCQUE and P.ROCOEUR, *Penser la Bible* ('texte d'Andre LaCocque traduit de l'anglais par Aline Patter et revi par l'auteur, La couleur des idees') (Paris, Editiones du Seuil).

[6] P. BEAUCHAMP, *Création et Séparation. Etude Exégétique du Chapitre Premier de la Genèse (Bibliothèque de Sciences Religieuses)* (Paris, Aubier Montaigne, 1969); *Idem, L'Un et l'Autre Testament. 1, Essai de Lecture (Parole de Dieu)* (Paris, Edition du Seuil, 1976). Italian edition: *L'Uno e l'Altro Testamento. Saggio de Lettura*, translated by Alfredo Moretti, edited by Lorenza Arrighi (Biblioteca di Cultura Religiosa, 46) Brescia, Paideia, 1985); *Idem, Psaumes Nuit et Jour* (Paris, Editions du Seuil, 1980). Italian edition: *Salmi Notte e Giorno*, translated by Giampaolo Natalini (Orrizzonti Biblici) (Assisi, Cittadella, 1983).

[7] S.UBBIALI, 'Teologia, Salute e Salvezza. La Rivelazione di Dio e i Beni dell'Uomo', in A.N.Terrin (ed.), *Liturgia e Terapia. La Sacramentalità a Servizio dell'Uomo nella sua Interezza* (= 'Caro Salutis Cardo', Contributi 10) (Messaggero – Abbazia di Santa Giustina, Padua, 1994), pp. 271-312; *Idem*, 'Il Male e la Libertà. La Sovrabondanza del Bene a la Contrarietà della Perversione', *La Scuola Cattolica*, 126 (1998), pp. 433-464.

Signs of Salvation: The Sacraments in the Health Care Ministry

Taking care of the suffering man in a situation of illness belongs to the very substance of the Gospel (cf. Lk 9:16; 10:19; Mt 10:58; 67-13...). This mission, which is the impulse behind, and the form of, pastoral action, involves the whole of the work of Jesus – his preaching, the healings, the calling and the building up of the believers. In the same way as it did for the Master, so, too, for his disciples does this have a global dimension: 'the Lord Jesus Christ, physician of our souls and bodies, wanted his Church to continue, in the power of the Holy Spirit, his work of healing and salvation, even among her own members'.[1]

From the early Christian centuries taking care of the sick has had a primary position of importance in the apostolic life of the Church. Hospitals were created by religious will and design. According to an inquiry carried out by the Pontifical Council for Health Pastoral Care in 1988, there are more than 22,000 health care institutions in the world which were founded by the Church and are still administered by her.

This ancient root has developed and grown in a consistent way in various forms and shapes depending upon the context and the situation in which it has found itself. Never before has the health care ministry acquired such a broad and inclusive set of horizons. From being the exercise of charity at the side of the bed of the sick person, it has expanded its horizons to the questions and issues connected with medical ethics, the environment, the quality of life, and the organisation of the health service.

This is not only a question of substitution or secondary support. Ten years or so ago Cardinal O'Connor, the Archbishop of New York (in that diocese the budget of the health care institutions exceeded a milliard American dollars every year) asked himself about the reason for so high a level of ecclesial commitment and involvement: was it not perhaps a good idea to leave such undertakings to government? The answer, emphasised the Cardinal, was simple and straightforward: because the Church believes in

the sacred value of each and every human being who is neither a number nor an object but a person who should be treated as a person, and because man is the way of the Church, it is through this care for man that there also necessarily passes the new evangelisation.

However, this ancient propensity is today subjected to dispute.

The Questions and the Issues

1. The Cultural Drift

We have before us foreseen disenchantment (Max Weber) and the dismay which has resulted from it, with its mixture of secularisation and superstition, doubt and credulity, with the aphasia of great tales (F.Lyotard) and the subtle attraction of the orientalising theosophical aura. This is a varied and complex panorama which impairs every metaphysical inflection (and every eschatological perspective), and brings with it the relativisation of all normative contents (the ethical aspect): the idea of an intrinsic moral quality to things and forms of behaviour disappears, and this comes to be substituted by a pragmatic reference to 'self-interest' which is at the basis of social control.[2] A greater (apparent) freedom, paid for with a marked subjectivism which closes up everything in a disappointing narcissism...

It follows that identity, rather than being realised through the following of prescribed codes (the knocking down of the mechanisms of social control, ethical emancipation...), is built not *in* but *as* biography – identity is no longer something which involves social roles and relations. In becoming one, none and a hundred thousand, man must search for his identity in a self-referential ego. The journey which was begun with the Cartesian '*cogito ergo sum*' thus ends up with its most disturbing result: 'not being able to be designated by the name that he bears, by the lineage from which he descends, by the country he comes from, by the land that he occupies, by the language that he speaks, by the religion that he professes, each and every person ends up by being defined by the clothes he wears, by the furniture and the objects with which he is surrounded, by the music he listens to, by the sport he plays, and by the words that he uses. The smallest practices of daily life have become the minuscule signs in which are written social classifications – distinctive signs which are distributed according to the generalised laws of the market economy'.[3]

An increasing disorientation for the individual, therefore, but also the aura of an independence which he does not wish to abandon. A mixture of tolerance and uncertainty, relativism and fanaticism. This is paradox-

ical, but really not so much so if Berger is right: 'the completely tolerant individual is *ipso facto* an individual for whom nothing is true, and in the final analysis an individual who *is* nothing. And it is from this terrain that fanatics spring'.[4] Tolerance understood as disengagement and a culture of 'anything goes'; a narcissism which oscillates between the Promethean (greatness, omnipotence, isolation...) and the parasitic (shallowness, vacuity, lack of planning).

Even the return of the sacred, proclaimed with empty hope, stretches between hypertrophy and evanescence. Indeed, it seems to many analysts that the very future of Christianity in the modern world is now a matter of doubt.

The transition from the *civitas* to the megalopolis, the rise of the 'global village', and then the virtual city, produces that dissection between the world-of-life and the world-of-systems which generates disappointment and dismay, the madness of various forms of loneliness.

Dispersion in the supermarket of sacred, anthropological, cosmic and superstitious – but above all else do-it-yourself – religiosity; the selective and weak reception of the Christian faith with a marked tendency to syncretism. A religiosity separated from socio-economic reality.

The institution of the Church is the element which is most involved in this crisis... but it is also the most 'resistant'. Religious practice decreases. Religious observance pre-supposes above all permanence. Today cities are from every angle poles of mobility.

Rapid urban development, which does little to favour the adaptation of individuals to urban life, is a factor which aggravates the decline in religious practice. But in the countryside as well, which has been transformed into the outskirts of urban life, religious practice is ceasing to be a dimension of collective life and is becoming instead a clearly fragile individual or private choice.

The parish tends to disappear within a frame of undifferentiated topography... it can also be a place for coming together for social and/or cultural activity, but it has a weak or absent relationship with the surrounding urban reality: 'in less than thirty years this parish civilisation, which is derived directly from post-Tridentine Catholicism, has disintegrated'.[5]

The prevailing of the world of systems over the world of life leads to the privatisation of religion, or to its mutilated public role – it becomes an agency of services in response to specific (socially useful/culturally irrelevant) needs and requirements. This observation leads directly to the subject of health: in this field as well the historic role and contemporary commitment of ecclesial realities is appreciated. But this is not true in relation to the cultural perspective which faith involves, both at the level of the way in which looking after health is conceived and at the very sensitive level of certain crucial bioethical questions.

The era of massification is at the same time the era of subjectification. Hegel's instinctive

perception throws light on this area and demonstrates a surprising and lucid foresight: 'Conformism and individualisation both have their roots in the fact that social bonds and relations have weakened and become less cogent... that the mobility of industrial society facilitates adaptation to models of behaviour that are socially accepted and equally favours withdrawal into the sphere of private and personal things far from social conventions and constrictions'.[6]

In this society, understood as a 'system of needs', men come together to associate, of necessity, only as the bearers of needs as producers and consumers. Everything that completes human life – culture, religion, tradition, nation, morality, etc. – is excluded from social relationships and left to each person's individual freedom,[7] unless people do not bend before the same logic and form a society of services. In this sense, religion no longer has anything to do with the principal goal of society but is instead recognised as having a function of relief and compensation. This also explains the marked scarce social relevance of the Christian approach. This increasingly appears to be a set of ethics which is only expressed as an abstract need – Christian love is emigrating from the sphere of justice and the social order...

For a religion, the critical moment arrives when it is subject to civil society rather than being its source of inspiration. In this profile all the diagnoses which are overly centred upon the existential and upon man must be corrected and supplemented. One can say, in a certain sense, that the Christian faith is socially irrelevant not because the world has become non-believing but because there is no longer a need for it in this arrangement of society – modern societies have learnt to keep themselves in equilibrium so that 'the functions of a normative culture, characterised by ideas shared by everyone, are becoming increasingly superfluous'.[8]

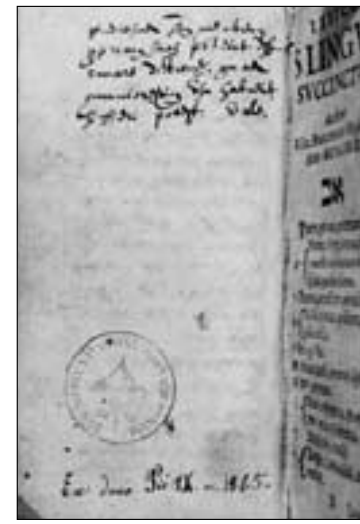
The prognostications of the prophets of secularisation should not be agreed with or assented to. However, it would be ingenuous to think that the contemporary situation is a temporary depression, a mere accident on a journey. It requires that new evangelisation which the Pope has been calling for now for quite some time.

Taking care of health is an essential chapter in this, both because the human suffering caused by industrial society essentially involves social isolation and takes the form of 'social death' and a lack of relationships – taking care of health in a situation in which the person is absent – and because the mystery of evil and the power of redemption are manifested in the taking care of health.

The loss of cultural relevance of Christian practice in the taking care of health and its intrinsic connection with the gift of salvation – in other terms the dimming of the overall sacramental value of the taking care of health, as an effective sign, even if only proleptic, of salvation – brings with it the subject of the purported therapeutic claims made by the new religious movements. Most of the people who take part in seminars of study, workshops, and group meetings aim at the health of the body and the spirit, and their starting point is an experience of deep existential difficulty. The ever increasing number of esoteric religious organisations which claim that they lead people to higher levels of consciousness also promise secure and effective therapeutic action. Located between gnosticism and syncretism, they invite people to fuse with nature and the cosmos in order to grasp the spark of great universal and spiritual Energy by means of an immediate and direct contact with the divinity to be found within us all. This is a new cultural paradigm which promises health and well-being in the immediate present.

They offer answers to the need for identity and harmony, and social safety, recognition and acceptance, through an atmosphere of warmth and nearness – so-called 'love-bombing' – and the guidance of a teacher. Some of these movements, such as Christian Science, influence not only the religious life of people but also their approach to illness and to health, and they do this to such an extent as to also become a 'religion of healing'.

The removal of illness and health from systemic, 'efficientist' and 'culturalist' society on the one hand, therefore, and on the other, a 'healthist' hypertrophy. This is what we are faced with. 'Industrialised society has individualised man as a producer and a consumer and has broken down his belonging to original communities. The family, the tribe, the village community are no longer his natural 'social associations' in the situations of childhood, illness, disability and old age. As a result, the modern state is compelled to organise the state system of welfare provision. Its services have to compensate the individual for the disintegration of the



pre-existing living communities. But because the industrial system does not take into account the national, cultural or other limits to society as a whole, the organisation of state services cannot but adapt itself to the disintegration of communities. This can clearly be seen in the mass movement of manual labour, capital and industrial plant from industrialised countries to countries which have low labour costs etc. But if the state as a 'welfare state' does nothing else but follow the changes in people's lives caused by industrialisation, it cannot in the least be said that it is the state which guides the destiny of the people'.[9] The 'eugenic temptations' which are coming forward in the sphere of assisted procreation manifest a propensity to yield to the temptation of utopia through seeking to achieve a biological perfection which eliminates the finite-

ness of man and thus illness and death as well.

2. The Difficulties of Pastoral Care

a. The Numerical Reduction in the Number of Presbyters and New Forms of Ministry

The spread of non-ordained ministries in the taking care of sick people (hospital chaplaincies...) involves the risk – not in itself but because of the concomitance of the reduction in the number of presbyters – of bringing about a thinning of the celebration of the sacraments in hospitals and in care for the sick. There is an accentuation of the tendency to place the gift of salvation within the categories (which are useful, where they are suitable, but which are always radically insufficient) of psychological support (that is to say 'clinical pastoral counselling').

b. A Half-Way Liturgical Reform

The fate of the liturgical reform promoted by Vatican Council II, with its difficulties and its misunderstandings (due not to the impulse of the Council but to the way in which it was received – too often selective, short-sighted, and futuristic), demonstrates to the full the difficulties of this path. To summarise, the principal failings which influence in a major way the celebration of the sacraments within a context of illness are as follows:

– the persistence of formal and executive forms of engaging in ritual;

– forms of language involving gestures and words which have little meaning; and

– arbitrary innovations and ceremonial 'selections'.

A sound concern with the faith of those who ask for the sacraments has at times led to a verbose form of liturgy with a strong didactic and/or paraenetic or hortatory emphasis which makes it heavy and also deforms it nature.

c. The Risks of Ambivalence and Falsification

Not in the sense – which should itself be rejected on the grounds of ambiguity! – which is indicated by Chauvet: 'the sacramental rituality thereby turns out to be especially ambiguous. Although on the one hand it is a privilege, on the other it is at the same time a trap. A mental trap – how many neuroses have been fostered or sustained by pious presence at the 'holy sacrifice' of the Mass, by the 'theophagy' of the Eucharist communion, or by the wish 'to say and reveal everything' in the hidden secrecy of the confessional...! A social trap: how many social and political strategies in the liturgical assemblies have not acted as an alibi (maintenance of the established order, of the civil or religious hierarchy, defence of privileges...)!'[10] But rather as a result of an always pending aporia between objective meaning and subjective reception; not only as a correct and good 'disposition' at a conscious level but as a real conditioning at an unconscious level. At this level both the symbolic capacity of the faithful and the capacity and symbolic congruity of the 'celebrant' are called into play: one is not dealing only with the productiveness of the sacrament but also with its objective exhaustion (even if human action will never be able to neutralise the effectiveness of divine action at an objective level but only to disfigure it and make it unrecognisable. This, indeed, it can do, and also in a very serious way).

There remains present therefore a self-referential which privatises the sacramental act – this diminishes the valid need for a celebration which is taken part in and felt, the personal 'relationality' of the salvific relationship (*tua agitur*, 'he loved me and gave himself for me'), into a folding in of the individual into himself which contradicts in essential terms both the theo-logical and the communitarian dimension of the sacrament.

Propaedeutics

1. The Patient and Tenacious Work of Redefining the Cultural Contexts

a. Communication

The health care ministry begins in the subtle lattice-work of communication where the conceptual and symbolic infrastructures of reference are formed in a way which is more or less unconscious, and precisely for this reason in a way which is more rooted. 'Reinhardt Koselleck has identified as a feature of modernity the reduction of the space of experience and the lowering of the horizon of expectations. This means that with the progressive acceleration of historical advance the past no longer throws significant light on the present, and the future is deprived of models on which to lean and thus becomes difficult to foresee and imagine. Expectation in this way experiences a double transformation: on the one hand with the distancing of the imprint of acquired experiences people are encouraged to direct themselves towards a search for the indeterminate, the unknown, and the new; on the other, faced with the complexity of events which are seen as ungovernable, they are pushed to drastically moderate their aspirations in relation to the future and to not engage in exorbitant requests with regard to it. The propensity towards the future as a result obeys simultaneously two contradictory tendencies: it is rendered more acute because the need for prediction increases and it is at the same time demotivated because the feeling is widespread that people are not up to the tasks of prediction and control. In other words, the horizon of expectations becomes lower when the future appears more as an indeterminate threat than as a promise full of contents and when the experience of it as a whole loses its characteristics of a meaningful and consistent continuity. The feeling of discomfort and disorientation in a fragmented world thereby spreads'.[11]

b. Preaching

The relevance of conventional preaching, which transmits the vision of faith in a simple and effective way, deserves discussion. In a world in which perhaps most men have lost or made uncertain a faith in the 'immortality of the soul' and in a world beyond this one, it becomes more difficult to think about, plan and implement one's own existence as a period of time which prepares the way for another life. For this reason, preaching urgently needs a rich

theological rethinking, of a wise and courageous character, which does not remove the pressing subjects of suffering and death but knows how to face up to them with illumination and a capacity for direction and meaning. The relationship between theology and pastoral care in health is neither accidental nor intrinsic. Without theology, diaconia becomes levelled down and becomes reduced to any kind of social action which is carried out by specialists and experts. No longer having clear roots and a secure identity, it falls victim to the anthropological ideas of the moment. Without diaconia, for its part, theology becomes separated from experienced witness, it becomes abstracted from, and no longer dialogues with, the community and with the world.

c. The Pastoral Vision

The ecclesial commitment to health extends the tasks of the Christian presence in the planet of suffering and medical care and treatment beyond the traditional celebration of the sacraments and the other liturgical rites.

Today the health care ministry involves cultural initiatives, the activation of specific training courses for hospital staff and personnel, and care for, and an increase in, professional and voluntary work associations. The figure and the role of the hospital chaplain are also approached anew in relation both to the action of the health care structures and to the local Christian community so that he can feel and act as the first agent of the health care ministry.

2. The Difficult and Inescapable Involvement of the Christian Catechesis

From 'Resignation' to Taking Care of Health

A surprising change in cultural approach – health as a project of society and of life.

The anthropological inflection of contemporary culture leads directly to an emphasis on the subject of health, and with the risks and the deformations to which reference has already been made in this paper. But also with the gain of a more complete sensitivity towards the Christian vision itself of man in the wholeness of his natural constitution and historical condition.

Solemn international declarations bear witness to, and in a certain sense codify, this shared and widespread sensitivity and awareness.[12]

The catechesis, which is the school of faith in the concreteness of specific historical, personal, cultural and social co-ordinates, discovers in this tendency of the contemporary mind a trace and an effect – even though it is only partly realised – of the Gospel words. It rediscovers them, indeed, in their value as an overall message of salvation for man and for the world.

Called to be a non-evanescent hermeneutic place of the strong moments of existence, the catechesis thus presents itself as an educational voyage during which the sacraments progressively also appear in their instructive value of welcoming and accompanying, an interior force of renewal and/or coaptation, and words of concrete help. This requires a catechesis which is able to present in a clear and convincing way the Christian propensity towards perceiving life in positive terms and seeing the gift of life as the centre of the work of creation and redemption (the tree of life – Jn 10:10). As something which is able to educate people as to the meaning of mystery (*sacramentum*!) as a dwelling place of meaning and not as the concealing of, or escape from, reality. Pain raises questions for, and shakes, human intelligence, but it cannot be reduced to a mere intellectual question. Only communion with the Cross unveils the abyss of evil but also the summit of redemption – the mystery of darkness becomes the mystery of redemption.

A culture immersed in hedonism, during the rush for success, and acting within the myth of eternal youth, places an opaque veil over the understanding of suffering.

Education in symbols, to which reference is often made in the catechesis, must develop within the person the ability to go beyond the plane of the phenomenon to draw upon (albeit *per speculum in aenigmate*) the plane of foundation (*Fides et Ratio*). This also implies a capacity which is not confined to the level of concepts and instruments but which is open to the sphere of meaning and relations.

This allows one to avoid the double counterposed drift towards hieraticisation and/or banalisation which threatens the celebration of the sacraments. Above all in a situation which is as essentially relevant and sensitive as illness, a dry as dust celebration would empty the sacramental sign and betray the words of salvation.

As has been seen, because of the worrying decrease in the numbers of presbyters as well, there is an increase in the risk that salvation will be reduced to something which exists within a reductive parameter of an omnivore theology of the Word. The effectiveness of the Word, rightly illustrated by *Dei Verbum*, cannot be separated from the sacraments, not can it in anyway take their place. This is a critical element which is also advanced in the world of Protestantism, as Pannenberg well observes: 'there remains only to ask ourselves if baptism and the Eucharist are really only illustrations of this verbal process, which would already contain in itself the salvific presence!'[13] From the reduction of the theology of the word to pastoral care of the word as the sole human consolation, the step is very brief!

In their narrative-symbolic dynamic, rites appear as a profound experience in which subjectivisation does not come about through the self-affirmation of the individual but rather through his conversion. In rites there operates an original and irreplaceable pedagogy of the faith which marks out life paths: 'rites are workers of existence, operators of images, matrices which generate experiences, and places of permanent maieutics'.[14]

The sacramental rite reminds man of his fact of being a creature through the radical unavailability of language: 'man does not possess language because he does not pre-exist it – instead he elaborates it within himself; indeed, he is possessed by it'.[15]

One should not, however, forget that whereas capacity for

symbols is natural, symbolic activity is cultural. It thus involves the catechesis in its work of training at the level of knowledge (in a total sense) of the faith. When this task is well understood and carried out, corporeality enters as a natural dimension into spirituality, as a constituent component to be celebrated. Not as a mere covering, an accessory which is cumbersome, but as a suitable form according to the law of the

incarnation. The Christian faith and its rites do not produce estrangement from reality, an escape into an imaginary world, but an ability to immerse oneself in life in forms and expressions which are always authentic, that is to say salvific. Things themselves then become transparent and reveal the mystery of God. All this belongs to the task of initiation of the catechesis because modern man is short-sighted, when that is to say he is not actually blind, when faced with symbols, because one dimensional (materialist) thought blocks him at the most superficial level of reality. 'Access to the world of symbols is made possible only by a developed capacity for perception – to know how to look, listen, touch, and reopen the gates through which our body places itself within the environment, that is to say to restore to the senses their genuine function, is the first and indispensable step by which to draw near to symbols. The appeal to symbols is, therefore, at the same time an invitation to rediscover one's own body, its modes and forms of experience and communion – I live, I feel, I perceive, I occupy a space, I am inserted into a field of interactions which ask questions at every level. Each symbol has its roots in reality, which indeed is accessible to the human senses, and for this reason we must exercise our senses if we want to understand the language of symbols'.[16]

References

'In his approach to the sick and to the mystery of suffering', we are told, 'an individual is guided by a precise conception of the human person and of his destiny in the design of God'.[17]

The Christian Conception of Corporeality

A rapid reference to the theological-practical dimension of the question is sufficient here. However, this is something which is necessary because a correct Christian perspective is far from being prevalent in the conception which is most widely spread in today's society. I will begin with the splendid patristic forms of witness which I will confine myself to quoting in a direct way:

– 'Represent God entirely occupied with the image of clay; to it He consecrates hands, thought, action, reflection, wisdom, foresight, and above all that love which inspired this project of His. Because everything was expressed in that clay, it was conceived with reference to Christ, who would become man, that is to say clay as well, and to the Word that would become flesh'.[18]

– 'Indeed, through the Son and the Spirit – because they signify those 'hands' of God – man, and not a part of man, becomes in the image and likeness of God... The perfect man is a mixture and union of the soul, which has received the Spirit from the Father, and of flesh, in which he is joined and shaped in the image of God'. Here shaped refers to both the soul and the flesh! 'When, instead, this spirit, fused with the soul, is united to the shaped body, through the effusion of the Spirit there arises a spiritual and perfect man: the man who is made in the image and likeness of God'.[19]

'With regard to man, God created him with his hands, taking very fine and pure earth and mixing in the right measure his force to the earth. To this end He impressed his likeness on His creature so that he expressed the image of God in his exterior appearance as well'.[20]

'Therefore man means above all modelled matter followed by the whole man. I would like to suggest this thought to you so that you realise that everything which was provided for and promised to man is not due only to his soul but also to his flesh, if not on the basis of shared origins at least because of the privilege implied in the term'.[21]

'Awake, man, and recognise the dignity of your nature. Remember that you are made in the image of God: wounded by Adam this was reshaped in Christ'.[22]

'The point of arrival of this path, in fact, is the end of human wishes. Now man desires two things in the main: firstly that knowledge of truth which is proper to his nature. Secondly, permanence in being, a property which is shared by all things. In Christ both are to be found... If therefore you are looking for where you should go, welcome Christ because he is the way: 'This is the road, travel down it!' (Is 30:21). St. Augustine says: 'Walk through man and you will reach God'. It is better to limp on the way than walk along off the path. The man who limps on the way, even if he goes only a little distance, nonetheless draws near to the end. The person, however, who walks along off the path finds that the faster he runs the more he distances himself from his goal'.[23]

We are still prisoners of the metaphysical dualism of Descartes if we affirm with him (or remain in the pre-comprehensive horizon) that matter is inert extension and spirit is unextended activity.

We therefore need to overcome, in preaching and in pastoral practice, an anthropology which is too narrow and which 'despises or at the least neglects this essential aspect in man, his relationship with the world'.[24]

In this respect I can but direct the reader's attention to the splendid vision of the anthropological, Christological, histori-

cal, essential and social that is to be found in the encyclical *Redemptor Hominis* of John Paul II.[25] This leads to a vision which perfectly integrates the deep personal aspect and the apostolic dimension of the commitment to fraternal solidarity: 'only in coming out of himself, in creative service to the world, does the individual experience his meaning and in it his salvation'.[26] Corporeality tends to communion, it goes towards the other (the Other). Sin inflicts suffering on the corporeality of man because it fractures communion. Redemption reconstructs the unity of the person and of persons because it knocks down the wall of separation and reopens access to the Father in a single Spirit.

The full positive appreciation of corporeality, in which the celebration of the sacraments writes itself at the summit (cf. Rom 12:1-2) does not put to one side the transience of the terrestrial body and its aspiration to salvific transformation, something which in the case of illness becomes especially dramatic and evident. 'For this perishable nature must put on the unperishable, and this mortal nature must put on immortality' (1 Cor 15:53). In the work of the Holy Spirit the continuity between the creational act and the sacramental act is to be found. 'If he should take back his spirit to himself, and gather to himself this breath, all flesh would perish together, and man would return to dust' (Job 34:14).

The Christian vision of health as a value (see e.g., Jn 1:1ss; Sir 30:14ss; Jn 10:10, without forgetting Gen 6:12: 'And God saw the earth and behold it was corrupt; for all flesh had corrupted their way upon the earth') does not for this reason fall into a facile and illusory optimism in which the correct vision of health as the overall well-being of the person in his environment forgets the fact that suffering cannot be suppressed and thereby becomes impeded in assessing it in a suitable way. 'Suffering seems to belong to the transcendence of man. It is one of the points where man in a certain sense comes to be 'destined' to rise above himself, and is called to this in a mysterious way'.[27]

The principal celebration of the seventh World Day of the Sick in Beirut involved dwelling upon the subject 'Request for Health, Nostalgia for Salvation'. In the sacraments, health (and its denial) are the tent of the encounter, in line with a deep nexus, attested to by the whole of the practice of Jesus: 'Christ teaches us salvation in healing us. He does this fundamentally through actions and signs (Mk 1 14ss). His, therefore, was a salvation offered sacramentally, that is to say it manifests and veils at the same time, a proposal to faith and to welcoming, freely effective and entrusted to the responsibility of man...'[28]

The Narrow Way

Afflicted health brings out the 'precariousness' of the human condition: the path then either falls into the depths of desperation (or its ataraxic sublimation) or it scrambles on the impenetrable path of the mystery of

pain on which with great difficulty the person's gaze opens up and expands to the horizon on which wishes and expectations progressively abandon the uncertain outlines of dreams or a utopia to encounter the question – and then the gift – of salvation.

The wish for health is a wish for the infinite and an invocation of salvation. It is necessary to combat, with a strong and multiform cultural action, the falsifications of the surrogates which mislead or the mystifications which reduce health to physical performance, to beauty, and to sporting and competitive energy.

Therapeutic capacity is pastorally suitable (and professionally excellent) when health is taken care of in the name and the perspective of overall salvation.

The Sacraments: A New Creation

Within the context of the renewed interest of religion in psycho-physical well-being, one can effect an enlightening re-reading of the subject of the effectiveness of the sacraments of faith. However, it is essential not to give way to facile fashions but to carefully verify the opportunities and the inevitable risks. One can certainly affirm that 'sacramental life produces the overall healing of the person' and share the critical approach towards a foreseen aphaxia of the celebration of the sacraments, even after the reform of Vatican Council II.[29] However, one cannot reduce salvation to the therapeutic sphere and one cannot indulge in forms of magical-superstitious evocations. The fact that many people allow themselves to be attracted by oriental philosophies and practices, and forms of religion of the New Age kind, or even by so-called alternative forms of medicine, must not lead to forms of adaptation which are equally suspect. But at the same time this cannot be underestimated as being a phenomenon which demonstrates a lack of satisfaction in relation to depersonalised medicine, on the one hand, and to a spirituality and a liturgy on the other which do not respond to the depths of meaning.

What should be the relationship between religious faith and the physiology of the body and health? Some recent research brings out a greater capacity for reaction on the part of religious people. The Christian conception of the person provides guidelines as to how to face up to illness and suffering, and turning to God in situations of difficulty is not a symptom of weakness but the perception of an ultimate reference point, of the origins and ends of our life. The wish for care and treatment which takes the whole of the person into consideration is alive and strong, that is to say an approach to health and healing in which the spiritual di-

mension is recognised as having a primary role in the facts of the case.

In the Background a Theology and a Mysticism of Creation

'*Accende lumen sensibus/infunde amore cordibus/infirma nostri corporis/virute firmans perpeti*'.

This is what Bulgakov calls the 'natural grace of the creation'. The world is not extraneous to God or hostile to Him: it is the work of His hands. At times a very poor interpretation of Christian faith has produced a marked lack of sensitivity towards the world and nature, or even a devaluation of everything that is material or corporeal. However, it is not possible here to discuss the bases or the limitations of this critical approach.

But it should be restated with great force that every devaluation (like every exaggerated evaluation) of terrestrial realities is to be located outside an authentic Christian perspective. The God of Israel, the God of Jesus, is the God of the creation and of history. The traces of the love and of the goodness which led God to the creation are to be found in terrestrial realities. Even medieval (Scholastic) theology stated this without hesitation: 'This action of the natural grace of the creation, breathed by the Holy Spirit into the creature, this soaring of the Holy Spirit which dwells and always continues over the waters of the creation, is the *positive* force of being'.[30] It is also the authoritative teaching of John Paul II: 'In this way the Church also responds to certain deep elements (ecology, New Age) which believe that they can read the hearts of the men of today: a new discovery of God in his transcendent reality of infinite Spirit, as presented by Jesus to the Samaritan woman; the need to worship Him "in truth and in spirit" (cf. Jn 4:24); the hope of finding in Him the secret of love and the force of a "new creation" (cf. Rom 8:12; Gal 6:15): yes, precisely *He who gives life*'.[31]

The beauty of nature has its strengths and its limitations. A sign of the work of the Spirit, a reflection of the perfect image of the Father, Christ, in whom everything is created, it also, however, is not in a state of perfection but of movement towards perfection. Because of the invasion of sin it was subjected to the risk of disfigurement, transience, annihilation: the 'grimace of being...'

We have to retrieve this dynamic and spiritual relationship with the created, but without falling into those forms of new superstition (modern gnoses) which lead to a liquefying of the relationship with nature into a pantheistic and psychologising identification which is very far from the Christian approach – the Spirit pushes us towards a relationship of responsible and creative commitment, which is, that is to say, cultural and not falsely mystifying.

This allows us to refer again to the stimulating work by Bulgakov: 'the creation possesses its own depth and its own strength. One could even say that the world has a created soul... The Spirit of God which hovers over the creation manifests through its force the forms of being hidden in Him... Theology thus meets natural science, which hopes to become the theology of nature'.(p. 323)

The creation is dynamism against nothing. In this way the world can take on that eschatological dynamism which constitutes its meaning and destiny. The creation is not only *ex nihilo*, it is also *contra nihilium*. Because of this liberating and promoting value, the creativity of man is linked in the biblical vision to *divine blessing* (Gen 1:28). This refers to the constant action of God in relation to man to achieve his salvation: His blessing, therefore, inserts from the moment of the creation of man (and correlatively of the world) a dynamism and orientation which find in His word ('and God said...') the indication of His project and in His action ('and God blessed them...') the propulsive force of realisation. In this way, the action of man within the universe is creative because it is originally, dynamically, and constitutively connected with the creative action of God, and through the close link of this with the history of salvation it receives from it vocation and salvific strength.

For this reason, the activity of man within the universe has a profound theological (salvific) meaning.

One can therefore positively affirm that man is to be found in a meaningful relationship with the world. The advance of science, although in an increasingly deep way it discovers the laws which regulate the universe with admirable perfection, and although it perceives with greater awareness (and less mechanics) its intrinsic logicality and correlation, finds itself increasingly powerless to understand its meaning. As the Nobel prize winner S.Weinberg puts it: 'the more the universe appears to be understandable, the more it appears to have no purpose'.[32] It is only in its relationship with man (and thus with God) that the universe can pass from the cold and impenetrable perfection of the scientific vision to the meanings of the vision held by faith: 'This is what we read in the first words of the Book of Genesis: "In the beginning God created the sky and the earth... and the spirit of God (*ruah Elohim*) descended on the waters"(Gen 1:1ss). This biblical concept of the creation involves not only the call to existence of the very being of the universe, that is to say the *giving of existence*, but also the presence of the Spirit of God in the creation, that is to say the beginning of the Salvific communicating of God with the things that he creates. This is true first of all of man, who was created in the image and likeness of God'.[33]

Two testimonies of special incisiveness from worlds which are different in terms of epoch and sensitivity, but which come from the same source-spring of faith, should here be presented to the reader:

– 'I, the most sublime and burning power, have lit every spark of life... I, the burning life of divine essence run shining through the beauties of the meadows. I shine in the waters and burn in the sun, in the moon, and in the stars. I with every breath of wind, which like invisible life maintains everything, awaken the whole of life. The air lives in the coming forth of green and of flowers. The waters flow as though they were alive... And thus do I lie, hidden in all reality, like a

burning force. Everything bursts into flame through Me just as the breathing of man is always in movement, similar to a flame shaken by the wind... To all things I give the breath of life... because I am life'.[34]

– 'Today, for the first time, I have understood what is meant by the statement that all things speak of God. He created everything and every single thing, He is behind every smallest reality. Everything, constantly, is recreated through Him. The person who experiences this, experiences God in everything. Always different, as this leaf is. And it is always Him. This was experienced by the Greeks when they saw each and every thing as being divine'.[35]

Approaches and Practice

Pastoral Action which Proclaims the Uniqueness of the Salvation of Christ

In the pastoral vision and pastoral practice the understanding of the sacraments as events of overall salvation finds response and almost reinforcement in the idea that the sick person is a sacrament of suffering Christ.

The proclamation of the salvific effectiveness of the sacraments does not give rise to any simple illusion. The sacraments open up hope, through death, not by by-passing it but by enduring its apparent victory in order to proclaim the real victory of Christ.

Furthermore, the removal of death (by the various ways which not only an instinctive mechanism of defence but today a more threatening and subtle cultural mystification constantly formulates and proposes) is an emptying of being and a dulling of knowledge. 'From death, from the fear of death, begins and is raised all knowledge about Everything'.[36] This is the overturning of the '*timor fecit deos*' of ancient memory and modern (Freudian) rediscovery. Without the thought of death, life would fold in on itself in a present foolishness which is drawn between aggression and dismay. The Christian vision locates the horizon of life and celebrates it, giving it a real beginning and visibility, in the sacraments. The sacraments tell the truth about life. They are the beginning of (real) life because eternity lies in being with Christ with the Lord (Lk 23:42ss; 2 Cor 5:6-8; Phil 1:23; 1 Theos 4:17). In this way, in the perspective of faith, there is healed that yearning, which would otherwise be only utopian, for completion,[37] and the redemption – at the level of meaning now and fullness later – of the intolerable in-significance of pain and death.[38]

The End of Time, the Time of the End. Hope and Pledge

'The path towards the Jubilee, while it refers to the first historical coming of Christ, also invites us to look forward in the expectation of his second coming at the end of times. This eschatological perspective, which indicates the fundamental tendency of the Christian existence towards ultimate realities, is a continuous appeal to hope and at the same time to commitment in the Church and the world. We must not forget that the *éschaton*, that is to say the final event, understood in Christian terms is not only a goal placed in the future but also a reality which has already begun within the historic coming of Christ. His passion, his death, and his resurrection constitute the supreme event of the history of humanity. This has by now entered its final stage, engaging thereby, so to speak, in a leap of quality. There is opened up within time the horizon of a new relationship with God, characterised by the great offer of salvation in Christ'.[39]

History is the place of Revelation and the space for its fulfilment. In the creation of man God impresses a dynamism according to which reference to nature does not indicate – as is the case with the animal kingdom – repetition (evolution, correctly understood by the various scientific theories does not markedly alter this picture, which is substantially static). Rather, it involves a norm of creativity. In other terms, man was created to live in and to cultivate the garden, to grow, to multiply and to dominate the earth. Neither arbitrarily nor independently, certainly, but according to the norm of nature, which in the constitutive image and likeness establishes his bond and creative projection in time.

Modern society favours the future (traditional society favours the past). But the falling curve of modernity is characterised by the fact that man no longer finds himself in front of a clear vision and a future which is seen as being progressive and certain. Instead, he 'is once again in front of chaos'.[40]

On the one hand, this appears as a very open and unconditioned possibility. 'With the entry of the future into the imaginable the secularisation of history comes to a conclusion. The unknown of the future, without a face and without a name, but which compels nothing, towards which no hidden determinism hurries, is the pure future, liberated from the theological tangle which continued to partly hide it for two centuries... This is its greatest paradox: it becomes more secular the more it is seen as belonging even more to the order of the invisible'.[41]

On the other hand, this involves an evident loss of recognisable perspectives on the future; the post-modern returns to myth. But it does not abandon mobility, the real fact of the modern. One time, our own, is defined perhaps more by escape from reality rather than by the dominance of reality, at least from an anthropological point of view. Contemporary culture displays a situation of stall and almost of the irrelevance of historical time. The fleeting moment is not only the title of a successful film of a few years ago, it also reflects a rather widespread perception (even though this perception is rarely worked out or rendered explicit). The faith itself of Christians has questions posed to it by the fleeting moment and suffers difficulty because of it. A fundamental and leading category is at stake: 'In Christianity time has a fundamental importance. Within its dimension the world was created, within it there takes place the history of salvation, which has its culminating point in the 'fullness of time' of the Incarnation and its end in the glorious return of the Son of God at the end of time. In Jesus Christ, the Word made Flesh, time becomes a dimension of

God... From this relationship of God with time is born the duty to sanctify it'.[42]

If time, instead, is confined to the present, if one does not give any overall meaning or meaning in terms of design to events, which take place without pausing without ever 'occurring'; if the only philosophy of history remains the disappointed '*carpe diem*' of Horace, there is no place for the very idea of creation and redemption, there is no place for Christ as the alpha and omega of history. Everything comes to be swallowed up by a present which is suspended in the void.

For the Christian faith a religious dimension is not given which is not – contemporaneously and substantially – an ethical dimension, involvement of existence in the construction of a new society of which the Church is the sign and the first fruit.'[43]

When the Christian involves himself, as a Christian and in response to the impulse of his own Christian faith, in the autonomous structures of the world of politics, of the economy, of science, and of culture, he does this in the knowledge that these structures remain autonomous and of this world. And yet the Christian is well aware that even the dignity of the creature, which is positive and 'autonomous', wounded as it is by sin, inexorably runs the risk of destroying itself when it is not made true by grace. The Christian belief is courageous and respectful: 'There exists, and one should not be afraid to affirm the point, a Christian qualification of culture because faith in Christ is not a pure and simple value amongst the values which the various cultures put at their centre. For the Christian it is the last judgement which judges them all, albeit in full respect for their own coherence'.[44]

This does not involve any prevarication, nor any mixing. The Church does not invade the sphere of state powers, nor does she merge with them.[45]

Motivations

The ecclesial agent who administers the sacraments does not enter merely at a functional level so as to constitute the sacramental sign.

One is certainly dealing with psychological maturity and upright intention, as J.Moltmann explains very well: 'The person who commits himself to social or diaconal action because he has not solved his own personal problems does nothing else but impose his own burden on others. Social action and the diaconia are not remedies for the weakness of the self. We have often seen in recent years students who sought to compensate for their internal emptiness with good works done for other people. In this way they have made those in need even weaker. The person who wants to help and to do something for others or the world, without having deepened his own knowledge about himself, his own freedom and capacity for love, will not find anything that he can give to others. Granted his good will and his good faith, he will do nothing else but communicate his own selfishness to other people, his fear, his aggression, his selfish ambitions, and his ideological prejudices. The person who wants to fill this emptiness through helping others will only spread this emptiness. Why? Because every person acts on others not so much with his own action as with his existence, and more than we activists would like to admit. Only the person who has found himself can give of himself. Only he who has recognised the reason for his own life can act in a rational way. Only the person who has become internally free from selfishness, from the weakness of the ego and of anxiety, can share and welcome suffering and free other people'.[46]

But not only as a predisposition. More deeply as a historical-existential truth of the sacraments. Their effectiveness achieved *ex opere*, indeed, does not render what constitutes their human component superfluous or marginal. Indeed, it is precisely the sacraments which fully appreciate and require, by their internal logic, the highest consistency between the visible sign and action, albeit always sovereignly freely given by grace.

To the necessary psychological maturity and interior clarity other requirements are thus added which take form from the very practice of Jesus:

– He shows that he is always interested in the inner man, even though there is a clear priority of the eternal over the temporal.

– For this reason he keeps a visible critical distance: a space of encounter in order to open the necessity of faith and a confident entrusting.

– Jesus does not confine himself to fighting symptoms or syndromes: he wants to encounter the sick person, defeat his estrangement (and at times social ostracism) through contact, nearness, and the saving encounter.

– Healing is a gift: no compulsory tie (even if gratitude is expected): open freedom even after the healing.

– The relevance of biography for the pastoral care of the illness (of the sick person) and for a fruitful celebration of the sacraments. A fact which the communicating tradition of the past has always considered (although certainly favoured by a much more homogeneous socio-cultural situation).

– You will never allow me to die alone in the anonymous death of a hospital... The eschatological dimension is real if it is not confined to sublimating the Christian action but really connotes it making it capable of criticism and suitable planning.

Specific Questions.
The Specific Ways of
Celebrating the Sacraments
in Situations of Illness
and Infirmity

According to the (theological) law of incarnation, the nature of

the sacraments – in its symbolic linguistic nature – writes the action of God into the reality of the human in the real dimension of corporeality and the internal dynamics of the human person, who in a certain way is connoted and conditioned (*kenosis*) by it. This confers (and requires) a different resonance of words and a different impact of gestures. As has been repeatedly observed in recent studies, in the celebration of the sacraments the illocutionary dimension prevails over the elocutionary. In this way, the form is a fundamental question. The communicative encounter is that in which a/the person/people reveal himself/themselves, that in which something takes place (an event). And the place of celebration is a symbolic space in which the architectonic structure, sound and music, the arrangement of objects, and the movements and actions of the various actors all constitute not only the con-text, or the pre-text, but the text itself of the sacramental event in the exercise itself of the functions for which they are respectively responsible.

In this symbolic practice one is dealing not with the transformation of the world but of itself in relationship with God. Everything thus converges on that nucleus which is the sacramental formula in a narrow sense, a formula incorporated in the gesture itself, in which the expression of faith reaches its full truth (for example the baptismal rituals of the ancient Church where the liturgical practice was the profession of the faith which was underway).

The messianic ministry of healing is completely the opposite of the removal of suffering. It does not remove it, nor does it sublimate it. It faces up to it and fights it; it understands and accepts the mystery of suffering. On the contrary, the lack of soteriological (existential) relevance provokes the evanescence of the Christological proclamation, and the eschatological reference appears as an escape route in the face of a powerlessness to heal.

Suffering as daily baptism marks out a way of conversion in which the Eucharist brings its own promise to fullness (‘*futurae gloriae nobis pugnus datur*’): the viaticum summarises the sacramental journey to salvation in the dimension of a company which is already a new beginning.

The Personal and Community Dimension: Balance and Reciprocity

Diaconia is worthy of the name ‘Christian’ only if it is based upon the agape of Christ. It expresses itself in and from the community, it addresses itself to everybody, without any form of discrimination (Gal 3:28; 1 Cor 12:1). The Eucharistic assembly is the point of departure, the narrative place where the word is a memorial and an announcement (event and practice) of salvation. This does not mean that the truth of faith depends on the verifiability of socially perceivable effects. It does not make them irrelevant; indeed, quite the contrary.

Welcome and Availability Above All

Pastoral dialogue requires evangelical questions to be raised (the encounter between the Gospel and the faith of the Church cannot be omitted or watered down in an attempt to achieve peace). But it also asks, on the other hand, that these questions are raised in the style of the Gospel. This means the welcoming of people as they are, in their concrete humanity, with their imperfect motivations (but who, one might say, can say that they are perfect?). The ethical approach does not generate moralism but pastoral care and concern so that its fragile flame can release full light.

Welcome also involves celebrations which can be understood and which are accessible. This does not mean a broadening of the didactic part, something which leads to a deformation of the liturgy and the boredom of the community, but, rather, making the rite alive and meaningful. This is a by no means easy task. Here, indeed, we have two apparently contradictory points – respect for the language specific to the liturgy in its symbolic and pragmatic inflection on the one hand; and on the other, taking into full account the upholding of intelligence and criticism which characterise our culture of suspicion, without however yielding to the intellectualist movement which falls back into itself.

Pastoral Subjectivity: The Sick Person Teaches the Healthy

To frequent the world of the sick is an authentic school of life, an apprenticeship which develops a capacity for discernment in relation to the fundamental questions of existence in an insuperable way. The sick person also shakes the most sluggish sensibility and reminds it of the most simple and profound values which in a situation of good health are often relegated, paradoxically enough, to a secondary level. It is a school for relationships. Even those relationships which are nearest and most intimate are understood afresh and aspects of them emerge which daily routine had left in the shade. There are thus enjoyed, albeit in the dramatic nature of the situation of illness, discoveries of humanity which would otherwise have remained latent. Conversely, we are put to the test because the patient asks for care and attention, reacts with acute sensitivity, and at times also puts the person who takes care of him with a generous spirit to the test as well.

The bed of the sick person is a teaching chair of spirituality and faith.

Conclusion

The training of those who are called to work in the world of health care is without doubt one of the primary concerns of contemporary society, which is so interested – even if not always in a positive or correct way – in the quality of life. The great transformations which characterise the modern age, above all during these recent decades which have opened up towards the third millennium, have deeply affected the identity and role of health care workers. These, no less than other professional figures (indeed, perhaps more acutely), feel the impact and difficulties of these transformations. This is observed in a strong way at the level of points of reference in terms of values and at the level

of new knowledge and technological and scientific approaches. These give rise to problems and difficulties which are by no means small; at times, indeed, they lead to regressions and backward steps which are deeply damaging. However, these reasons for worry and concern should not lead us to forget that during our epoch new prospects and horizons are being opened up of a very great and positive nature.

First of all, reference should be made to the cultural widening of the concept of health, something which is no longer confined to an absence of illness and the clinical structures which are dedicated to the treatment of such illness. This has taken place with undoubted advances but also with equivocal extensions which, by identifying the value reference points in a social practice which is subject to alteration, bring about approaches, forms of behaviour, and legislative codifications which are contrary to the fundamental rights of the person. Based upon a markedly subjectivistic cultural platform, the expansion of the concept of well-being – which is in itself positive – thus runs the risk of rebounding against man, while the desire for life, which is anchored only in a self-referential way, declines into a culture of death. All of this calls Christians to a commitment which is more convinced and stronger, as the Pope reminded us in the encyclical *Evengelium Vitae*: 'the task of accepting and serving life involves everyone; and this task must be fulfilled above all towards life when it is at its weakest. It is Christ himself who reminds us of this when he asks to be loved and served in his brothers and sisters who are suffering in any way: the hungry, the thirsty, the foreigner, the naked, the sick, the imprisoned... Whatever is done to each of them is done to Christ himself (cf. Mt 25:31-46).'[47]

A specific and special task, in this framework, falls to academic institutions – a role of increasing relevance from a scientific and cultural point of view. In such institutions, thought imbued with faith, matured in the cultivation of a robust spirituality enlightened by the observations of the Magisterium, produces not only strengthened personal beliefs but precise formative paths. A salient feature of these is the constant search for the deep, and I would like to say inner, quality of the medical profession, in the heart itself of the Gospel of life. And in a way that Christian faith does not appear only as an additional moment or an ethical border but as an original and special factor of the harmonic and positive expression of the capacity that the work of God the creator


DVE ORATIONI
DI GREGORIO NAZANZENO
TEOLOGO.
IL PRIMO SERMONE
DI S. CECILIO CIPRIANO
FATTE IN LINGVA TOSCANA
DAL COMMENDATORE
ANNIBAL CARO.
IN VENETIA.

places from the outset in the hands of man and the salvific gift of the passion of the Redemptor which redeems evil and raises up to an always new expansion of life. In this way, incarnating itself in a competent and wise professionalism, the word of the Gospel proclaims the opening up of the horizons of life onto eternity – not tearing it in the least but rather increasingly positively and involvingly immersing it in time and history.

There is thus achieved at a deep level the unity of faith and of life to which Vatican Council II called our attention: 'The Council exhorts Christians, who are citizens of different cities, to strive to carry out their earthly duties faithfully, making themselves be guided by the spirit of the Gospel. Those are in error who, knowing that we do not have here a stable citizenship but instead search for that of the future (Heb 13:14), think that they can neglect their earthly duties... The detachment, which is to be observed in many people, between the faith that they profess and their daily lives, is to be listed among the most serious errors of our times. For this reason there should not be opposition, without good reason, between professional and social activity on the one hand and religious life on the other' (*Gaudium et Spes*, 43).

The Christian faith therefore proposes an overall vision, which is unitary but not static, of the world and life. For this reason, in addition to the necessary knowledge of the Catholic faith at the level of its doctrinal and moral implications, it would be highly opportune for faculties of medicine to give space and importance to the study of the social doctrine of the Church, above all else through research and exchanges of an interdisciplinary character between the various faculties. In this way, in addition to framing formative paths which are more harmonious and understandable, one can set in motion an overcoming of that accentuated fragmentary character of knowledge which characterises the present-day configurations of university teaching in a separateness which damages the overall training of the person.

The identification of relationships which are established today between social praxis and the concept of health thus demonstrate themselves to be, when understood in the light of faith, a suitable and appropriate path for a relaunching of the profiles of professional ethics which are now so necessary, especially in the medical field.

This is an appeal which has a value which is completely special: 'What is urgently called for is a general mobilisation of consciences and a united ethical effort to activate a great campaign in favour of life. All together we must build a new culture of life; new because it will be able to confront and solve today's unprecedented problems affecting human life; new, because it will adopted with deeper and more dynamic conviction by all Christians; new, because it will be capable of bringing about a serious and courageous cultural dialogue between all parties'.[48]

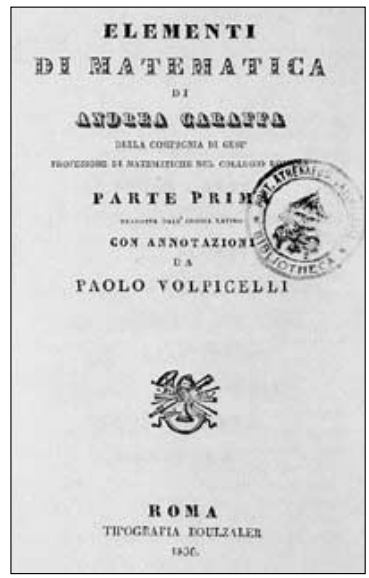
Enjoyed and/or refound health manifests the mystery of

the human condition and reveals 'in the flesh' the mystery of the compassion of God, creator and redeemer. It is an introduction to the immense mystery of death and foreshadows the blessed resurrection.

Prof. MONS. SERGIO LANZA
Director of the Pastoral Institute 'Redemptor Hominis'.

Notes

[1] *CCC*, 1421.
[2] Cf D.MARTIN, *A General Theory of Secularization* (Oxford, 1978).
[3] P. BOURDIEU, *La Distintion* (Paris, 1979), *La Distinzione* (Il Mulino, 1976).
[4] P.L.BERGER, *Una Gloria Remota...*, p. 73.
[5] D. HERVIEU-LEGER, *Verso a Nuovo Cristianesimo?* (Brescia, 1989), p. 59.
[6] H. SCHELSKY, *Die Skeptische Generation* (1963), 2, p. 297.
[7] J.MOLTMANN, *Teologia della Speranza* (Brescia, 1966), pp. 316ff.
[8] F.X.KAUFMANN, in F.X.KAUFMANN AND J.B.METZ (ed.), *Capacità di Futuro* (Brescia, 1988), p. 68.
[9] J.MOLTMANN, *Diaconia. Il Servizio Cristiano nella Prospettiva del Regno di Dio* (Turin, 1986), p. 22.
[10] L-M.CHAUVET, *Linguaggio e Simbolo...*, p. 150.
[11] R.BODEI, 'La Salvezza Laica. Miti e Utopie della Rivoluzione Francese', in G.FERRETTI (ed.), *La Ragione e i Simboli della Salvezza Oggi* (Genoa, 1990), p. 80.
[12] For example: the Universal Declaration of Human Rights (10.2.1948), art. 25,1: 'every individual has the right to a standard of living sufficient to guarantee his own health and well-being and that of his family'. The Constitution of the World Health Organisation (1946), art. 1: 'the objective of the Organisation will be to obtain for all peoples the highest level of health' (see also the 'Preamble': responsible governments: health as a subject of international policy; the Declaration of the Rights of the Child (20.11.1959): 'the child must benefit from social security. He must be able to grow and develop in a healthy way. To this end medical care and treatment and suitable social protection must be guaranteed to him and his mother, especially in the period before and after birth. The child has the right to nourishment, a home, entertainment, and suitable medical care and treatment'. The Italian Constitution, art. 32: 'The Republic defends health as a fundamental right of the individual and interest of society as a whole and guarantees free care and treatment to the sick'.
[13] W.PANNENBERG, *Teologia Sistematica*, 3, (Brescia, 1996; Gottingen, 1993), p. 374.
[14] G.SOVERIGNO, *Rito e Persona. Simbolismo e Celebrazione Liturgica: Asperri Psicologici* (Padua, 1988), p. 62.
[15] M.L.CHAUVET, *Du Symbolique au Symbole. Essais sur les Sacrements* (Paris, 1979), p. 20.
[16] O.BETZ, *I Simboli per Comunicare l'Esperienza a la Fede* (Frascati, 1990), p. 6.
[17] *DH*, 2.
[18] TERTULLIAN, *De Resurrectione Mortuorum*, 6, 3-4.
[19] IRENAEUS, *Adversus Haereses*, 5, 6, 1.
[20] IRENAEUS, *Espositio Praedicationis Apostolicae*, 11.
[21] TERTULLIAN, *De Resurrectione Mortuorum*, 7.
[22] LEO THE GREAT, *Sermo*, 27, 6.
[23] THOMAS AQUINAS, *Esposizioni su Giovanni*, chap. 14, lectio 2 (comment on 'Io sono la via', Jn 14:6).
[24] CTI, 'Alcune Questioni Riguardanti la Cristologia', *Civ. Catt.* 131 (1980), 4/278.
[25] In particular nn. 11-15.
[26] H.U.VON BALTHASAR, *Verità del Mondo* (Teologica II, Milan, 1987), p. 66.
[27] *SD*, 2.


ELEMENTI
DI MATEMATICA
DI
ANDREA CARAFFA
DELLA COMPAGNIA DI GESU'
PARTE PRIMA
CON ANNOTAZIONI
DA
PAOLO VOLPICELLI
ROMA
TIPOGRAFIA BOULZALER
1856.

[28] F.ALVAREZ, 'El Evangelio, Fuente de Vidaen el Mundo de la Salud y de la Enfermedad', in *Camillianum*, 11, (1995), p. 46.
[29] A.LANGELLA, 'La Funzione Terapeutica della Salvezza nell'Esperienza della Chiesa: Sguardo Diacronico e Riflessione Sistematica', in N.Terrin (ed.), *Liturgia e Terapia. La Sacramentalità a Servizio dell'Uomo nella sua Interezza* (Padua, 1994), p. 126: 'Sacramental theology and liturgy, even after the reform of Vatican Council II, have only implicitly restored the therapeutic role of the sacraments'.
[30] S.BULGAKOV, *Il Paraclito* (Bologna, 1971; Paris, 1935), p. 321.
[31] *Dominum et Vivificantem*, 2.
[32] S.WEINBERG, *I Primi Tre Minuti* (Milan, 1977), p. 170.
[33] *Dominum et Vivificantem*, 12.
[34] H. VON BINGEN, *Welt und Mensch (Da Operatione Dei)* (Salzburg, 1965), p. 25.
[35] R.GUARDINI, *Wahrheit des Denkans und Wahrheit des Tuns* (Padeborn, 1985(4)), diary 24 August 1953.
[36] F.ROSENZWEIG, *La Stella della Redenzione* (Casale Monferrato, 1985), p. 3.
[37] P.RICOEUR, 'Miti della Salvezza e Ragione Contemporanea', in Ferretti (ed.), *La Ragione e i Simboli della Salvezza* (Genoa, 1990), p. 30: 'The question which should be raised is that of knowing whether a society can live without a collective project, without a directive utopia. This is the question posed by R.Kosellec in *Vergangene Zukunft*. Is the structure of historical time, which is not represented but lives and put to work, made up of the polarity between horizon of expectation and space of experience, something which can be overcome? And is there still a horizon of expectation when there is no longer utopia, when what E.Bloch has called the 'Principle-Hope' has gone?'
[38] *Ibid.*, p. 31: 'Thus I ask myself the question which I will leave this evening without an answer: in the same way in which the idea of progress has been for the modern period the secularised equivalent of a secularising *Heilsgeschichte*, does there not take form today, in the epoch which some call post-modern, a new face to face between the preaching of the madness of the cross and the *kènosi* of Christ and the decayed forms of the Hegelian philosophy of history? And if one asks what Christians still have to say on the matter, I answer: the hope that in a way which is unknown to us the histories of victims, defeated and scattered histories, will collaborate with the Kingdom of God which will come. A hope which, without doubt, is itself mad...'
[39] JOHN PAUL II, Catechesis of Wednesday, 22 April 1998.
[40] R.GUARDINI, *La Fine dell'Epoca Moderna* (Brescia, 1993(8); Basel, 1950), p. 74.
[41] M.GAUCHET, *Le Dèsenchantement du Monde* (Paris, 1985), p. 267.
[42] *TMA*, 10.
[43] C.RUINI, *Il Vangelo nella Nostra Salute. Chiesa, Cutlura e Società in Italia* (Rome, 1989), p. 76: 'The inseparability of the religious dimension from the ethical dimension constitutes the fundamental structure of the Old Testament, from the covenant of Sinai to prophetic preaching. In the New Testament love for God and love for one's neighbour make up an indivisible unity in which we address ourselves to everybody, including our enemies, up to the point of 'turning the other cheek'. In Holy Scripture there is no dualism between intention and action (just as there is no dualism between 'soul' and 'body', but rather at the same time the most radical penetration into the centre of the person (the 'heart'), against the exteriority of legalism, and the most rigorous concreteness of the 'works of love'. Not only solidarity towards the poor man, but also justice are fully included: Christian love is not a surrogate for justice, and not even simply a development which goes beyond it, as is often thought in opposing quarters. On the contrary, love involves justice as an essential part of itself... It is true rather that justice can be fully achieved only through love, that is to say by opening ourselves to the other, giving ourselves to him, and accepting him in his quality as a man. Here a very solid thread links the preaching of the prophets with the words of Jesus, the Gospel, and the First Letter of John and the First Letter of James, to cite only a few meaningful examples'.
[44] JOHN PAUL II, Homily 8 February 1984.
[45] Vatican Council II, *Gaudium et Spes*, 76: 'The Church, because of her office and her role, in no way can blend with the political community and is not linked to any political system. She is at one and the same time the sign and the safeguard of the transcendent character of the human person... In preaching the evangelical truth and throwing light on all the sectors of human activity with her doctrine and with the witness borne by Christians, she also respects and promotes political freedom and the responsibility of citizens'.
[46] J.MOLTMANN, *Diaconia. Il Servizio Cristiano nella Prospettiva del Regno di Dio* (Turin, 1986), p. 37.
[47] *EV*, 43.
[48] *EV*, 95.

Conclusions of the Work Groups of the Study-Seminar on 'the Sacraments in Pastoral Care in Health'

The Pontifical Council for Health Pastoral Care promoted and organised a study-seminar on 'the sacraments in pastoral care in health' which was held on 2-3 June 2000. This was organised and promoted together with the Pastoral Institute 'Redemptor Hominis' of the Pontifical Lateran University and was addressed to theologians, experts and workers who are active in various capacities in the world of health and suffering.

Certain observations and proposals emerged from the work groups over these two days:

1. Contemporary society presents itself as an entity which is divided into specialisations. Pastoral care also requires specialisation. However, this is not free from risks, and in particular those which are run when separating contexts which are strictly connected in pastoral terms and which can only produce positive outcomes if taken together.

During the debate, despite being based on concrete situations, a certain difficulty in integrating the different basic perspectives to which each person referred became evident. Two different kinds of pastoral approaches emerged: one which followed a substantially applied way of doing things, and another which moved in the direction of the method of evangelical initiative.

The situation of contemporary pastoral care reveals from different angles what are by no means marginal failings. The training of extraordinary ministers for the Eucharist is often inadequate, and this is something which compromises the understanding of the meaning of the sacrament and its full reception – we live in a situation of weakness with regard to the preaching of the Good News. Hospitals also experience a situation of incomplete evangelisation – the present is crystallised without an eschatological hope being provided.

2. It is necessary to share the pain of the sick person beginning with the illness. The attitude of the worker of pastoral care in health involves compassion (in the etymological sense of 'with' passion), of drawing near to the situation of precariousness and concern, but it also involves openness to the great questions of the meaning of life which are provoked by the state of illness.

At times the very celebration of the sacraments runs the risk of falling into forms of a miracle-working kind. Too often the person who is suffering in his body searches for a 'magic potion' to achieve recovery from his illness, and in this way he confuses the sacraments with miracles. The celebration of the sacraments is the end point of what has been careful preparation, a real and authentic journey of healing the soul. Only after this has taken place can one think of special celebrations with special spaces for the sick person.

In this context a specific space is opened up for the involvement of members of the laity who can draw near to the sick person with a more direct perception of his family and social condition.

The relationship with the sick person must be experienced as a mutual exchange – the sick person, too, catechises. Too often in hospitals the figure of the psychologist is more present than the figure of the chaplain. In this way the marginalisation of the sacraments is accentuated: the relatives themselves, rarely helped to understand the therapeutic value of the sacramental event, impede its celebration and maintain that it is a dark harbinger of death. At the root of everything there is a lack of a catechesis on death – death as a fundamental stage of life. The sick person is fundamentally alone, abandoned by a society which runs and cannot stop to spend time with the sick person. But even more serious is the abandonment of the sick person by the ecclesial community. The hospital is becoming a company, a machine where the chaplain is a man of urgency and not of serene steps, and it is too often the case that seminarists who are not prepared theologically or materially are chaplains in contact with suffering, pain, and death.

A careful training of seminarists is also required where the formative path towards being a presbyter achieves an authentic human and spiritual maturity which is capable of understanding and sharing situations of suffering. Pastoral care in health is an education

to be faced up to as early as the pre-school and school age. A real preparation for the workers of the sector is of primary importance – 'put your heart in those hands!' (St. Camillo). Through care for the body passes care for the soul. Care for the sick and care for the elderly should be approached in different ways.

In the dioceses pastoral care in health must be organised and arranged in a better way and there should be a specific delegate. Time should be dedicated to thinking about, and motivating, the sacrament of the anointing of the sick. Its need and value should be pointed out; the sick person's fear of this sacrament, which is seen exclusively as a preamble to death, should be uprooted from his mind. A fundamental step is to recreate and re-establish the overall vision of pastoral care and its health care dimension – how do we behave towards illness and death?

The alienation of death is important. Everybody dies alone, in a hospital bed, in a nursing home. The death of a relative is no longer experienced within the family as a natural event but as something which has nothing to do with any of us because when it arrives the person who undergoes it has already been expelled from the family, from the community.

Listening is fundamental in suffering. Desperation cannot listen if it is not listened to. Only after listening can one install a dialogue. During illness the very capacity to feel oneself in communion with God sometimes vacillates. The place of encounter is acceptance of illness – this is the propitious moment for drawing near to the sacraments and living them in their totality. The Eucharist is then seen as sharing offered during the celebration which becomes in a certain way participation in the suffering of God and men. And this to be new and alive people in illness as well.

The Magisterium presents the sick person as a pastoral

subject and not only as the object of care and treatment. In illness feeling that one is a subject is of fundamental importance. At a moment in which the capacity to act physically is reduced or diminishes, it is important for the sacraments to be rediscovered as action and not as passivity. In rediscovering the value of baptism one can also reach an acceptance of suffering and death – baptism as the way of the faith and as understanding of the faith. It is important to proceed systematically in the preparing of people who work in the medical sector in line with their different vocations and professional responsibilities. They should be offered a differentiated, adequate and personalised preparation. The chaplain, for his part, must effect a strong action of raising of awareness and sensitivity in relation to the sick person.

3. To summarise, the meeting centred around the following question: how can we foster in believers an adherence to Christ which is intelligent and affective, a context within which it is possible to celebrate and receive the sacraments as real events of grace for life?

Some theologically relevant elements should be emphasised: the centrality of Christ in the sacramental celebration; the need for the faithful to be directed towards the mystery of Christ through that celebration; and the relationship between suffering and sin.

Some proposals worthy of note emerged at the end of the meeting:

1. That the whole of pastoral action should be directed towards permanent education in relation to the sacraments as a meeting with Christ and an experience of the love of God towards us.

2. That pastoral workers should be trained in accompanying, understood as a reawakening to the truth of God.

3. That in the future there should be hospital pastoral services which are institutionalised, professionalised, and organised.

In order to produce pastoral care in health which is more qualified and qualifying the whole of the pastoral care of the local Church is of importance. Furthermore, it is necessary to proceed to a new look at the 'New Rite of the Sacrament of the Anointing of the Sick' where the rite is enriched with celebrations and prayers on the part of the Christian community with and for the sick.

It is also necessary to face up to thinking about death with courage by reproposing the Viaticum as a celebration of *the last communion.*

The discussion dwelt upon the need to bring out the following requirements:

1. An elaboration of the concept of *health* in a spiritual-transcendent perspective.

2. A reaffirmation of the centrality of Christ in the Church and for the Church in her pastoral action.

3. The figure and the mode of action of the ordained minister is of decisive importance – he must direct himself towards spiritual care for the person and not confine himself to being a mere administrator. For this reason, it is necessary to study forms and working models which foster and promote an approach of a therapeutic character.

Prof. Mons. SERGIO LANZA
Dean of the Pastoral Institite
'Redemptor Hominis'
of the Pontifical Lateran University.

Ninth European Congress
of the FEAMC

Twentieth World Congress
of the FIAMC

Tewnty-second National
Congress of the AMCI

Medicine and Human Rights

Rome, 3-7 July 2000

Prayer Written by the Holy Father for the Congress of Catholic Medical Doctors

Lord Jesus,

Divine Physician, who in your earthly life showed special concern for those who suffer and entrusted to your disciples the ministry of healing, make us ever ready to alleviate the trials of our brethren. Make each one of us, aware of the great mission that is entrusted to us, strive always to be, in the performance of daily service, an instrument of your merciful love. Enlighten our minds, guide our hands, make our hearts diligent and compassionate. Ensure that in every patient we know how to discern the features of your divine Face.

You who are the *Way,* provide us with the gift of knowing how to imitate you every day as medical doctors not only of the body but of the whole person, helping those who are sick to tread with trust their own earthly path until the moment of their encounter with you.

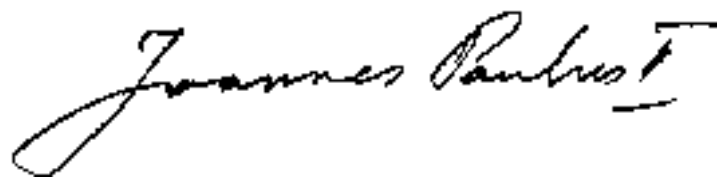
You who are the *Truth,* provide us with the gift of wisdom and science in order to penetrate the mystery of the human person and their transcendent destiny as we draw near to them in order to discover the causes of their maladies and find suitable remedies.

You who are the *Life,* provide us with the gift of preaching and bearing witness to the 'Gospel of life' in our profession, committing ourselves to defending it always, from conception to its natural end, and to respecting the dignity of every human being, and especially the dignity of the weakest and the most in need.

Make us, O Lord, *Good Samaritans,* ready to welcome, treat, and console those we encounter in our work. Following the example of the holy medical doctors who have preceded us, help us to offer our generous contribution to the constant renewal of health care structures.

Bless our studies and our profession, enlighten our research and our teaching. Lastly, grant to us, having constantly loved and served you in our suffering brethren, that at the end of our earthly pilgrimage we may contemplate your glorious countenance and experience the joy of the encounter with you in your Kingdom of joy and everlasting peace.

Amen.



The Vatican, 29 June 2000

The Medical Doctor should Respond as a Conscientious Objector to Legislation in Favour of the Crimes of Abortion and Euthanasia

THE SPEECH OF THE POPE TO THE PARTICIPANTS AT THE INTERNATIONAL CONGRESS ON THE SUBJECT "MEDICINE AND HUMAN RIGHTS"

1. I extend a cordial welcome to you all, dear Catholic doctors who have come to Rome with your family members to attend the international congress organized by the Italian Catholic Medical Association, the European Catholic Medical Association and the International Federation of Catholic Medical Associations. The principal aim of your meeting in the Eternal City is to celebrate your Jubilee. I fervently hope that, refreshed by this timely spiritual break, you will able to give fresh, courageous vitality to your Gospel witness in the important area of medicine and health care.

I greet you all affectionately, beginning with Cardinal Dionigi Tettamanzi, Archbishop of Genoa, and Professors Domenico Di Virgilio, Paul Deschepper and Gian Luigi Gigli, Presidents respectively of the abovementioned associations. And I greet Fr Feytor Pinto and Fr Valentini Pozaic, along with the ecclesiastical advisers present.

I also extend my greetings to Archbishop Javier Lozano Barragán, President of the Pontifical Council for Health Pastoral Care, an institution which I entrusted with the task of encouraging and promoting the work of formation, study and action carried out by the International Federation of Catholic Medical Associations, especially in the context of the Jubilee Year.

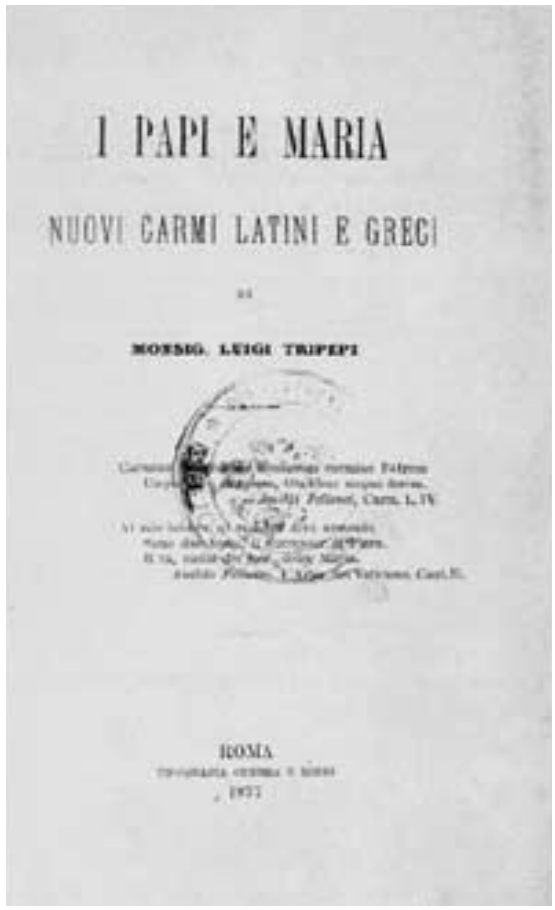
I lastly offer my particular thanks to prof. Domenico Di Virgilio, who has well expressed the sentiments you share and your loyal fidelity to the Chair of Peter.

Offer the sick the warmth of genuine human contact

2. The theme chosen for your congress – *medicine and human rights* – is very important, not only for the cultural effort it expresses of combining medical progress with the ethical and juridical requirements of the human person, but also for its timeliness because of actual or potential violations of the fundamental right to life, on which every other personal right is based.

Every day in your professional work you render a noble service to life. Your mission as doctors puts you in daily contact with the mysterious and wonderful reality of human life, prompting you to be concerned for the sufferings and hopes of our many brothers and sisters. Persevere in your generous dedication, showing particular attention to the elderly, the sick and the disabled.

You have first-hand experience that in your profession medical care and technical services are not enough, even if provided with exemplary professionalism. You must also be able to offer the sick that special spiritual medicine which is the warmth of genuine human contact. This can restore the love of life of your patients, inspiring them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to struggle for it with an inner determination that is sometimes decisive for their recovery.

The sick must be helped to regain not only their physical health, but also their psychologial and moral well being. This presupposes that the doctor, in addition to his professional skill, also has an attitude of loving concern inspired by the Gospel image of the Good Samaritan. With every suffering person, the Catholic doctor is called to bear witness to those higher values which have their firmest foundation in faith.

3. Dear Catholic doctors, you know so well that it is your indispensable mission to defend, promote and love the life of every human being from its beginning until its natural end. Today, unfortunately, we live in a society dominated both by an abortionist culture, leading to the violation of the fundamental right to life of the unborn, and by a concept of human autonomy expressed in the demand for euthanasia as self-liberation from a situation which for some reason has become distressing.

You know that it is never licit for a Catholic to be party to an alleged right to abortion or euthanasia. Since legislation allowing such crimes is intrinsically immoral, it cannot represent a moral imperative for the doctor, who will rightly have recourse to conscientious objection. The great progess made in recent years in the palliative treatment of pain make it possible to provide suitable care for the difficult situations of the terminally ill.

The many disturbing ways in which health and life are attacked should be courageously addressed by every person who truly respects human rights. I am thinking of the destruction, suffering and death that afflict entire populations because of conflicts and fratricidal wars. I am thinking of the epidemics and diseases that occur among populations forced to abandon their lands and flee into the unknown. How could we remain indifferent to the agonizing scenes of children and the elderly living in intolerable situations of hardship and suffering, especially when they are denied even the basic right to health care!

A vast field of action lies before you, dear Catholic doctors, and I express my heartfelt appreciation to those of you who courageously decide to dedicate some of their time to people in situations of such dire emergency. Missionary cooperation in the health-care field has always been openhearted, and I fervently hope that this generous service to suffering humanity will continue to grow.

Health-care personnel need moral and religious preparation

4. As we enter the third millennium, men and women, especially in the poorest countries, are unfortunately still deprived of access to health services and the essential medicines for their treatment. Many of our brothers and sisters die each day of malaria, leprosy and AIDS, sometimes in the midst of the general indifference of those who could or should offert them support. May your hearts be attentive to these silent please! It is your task, dear members of Catholic medical associations, to work so that every person, regardless of his social or economic status, can exercise his primary right to what is necessary for restoring his health and thus to adequate medical care.

Some of you are researchers in the biomedical sciences, which by nature aim at advancing, developing and improving the conditions of human health and life. I urgently appeal to them to make a generous contribution to providing humanity with better health conditions, while always respecting the dignity and sacredness of life. Everything that is scientifically possible is

not always morally acceptable.

When you return to your respective nations, take with you a desire to continue with new zeal in your work of formation and updating, not only in the disciplines associated with your professions, but also in theology and bioethics. It is very important, particularly in the nations with young Churches, to see to the professional and ethical-spiritual formation of doctors and health-care personnel, who often have to confront serious emergencies calling for professional skill and suitable preparation in the moral and religious field.

5. Dear Catholic doctors, you congress is providentially occurring during the Jubilee, a favourable moment for personal conversion to Christ and for opening your hearts to those in need. May the fruit of your Jubilee celebration be a deeper concern for your neighbour, a generous sharing of knowledge and experience and an authentic spirit of solidarity and Christian charity.

May our Blessed Lady, *Salus infirmorum*, assist you in your complex and necessary mission! May St. Giuseppe Moscati be your example, so that you will never lack the strength to bear witness with consistency, complete honesty and absolute integrity to the "Gospel of life"!

Thanking you again for your visit, I implore the Lord's constant benevolence for you, for your families and for everyone entrusted to your care, as I whole-heartedly impart to all a special Apostolic Blessing.

Greeting to the the Medical Congress on 'Medicine and Human Rights'

A cordial greeting to the organisers of the ninth European, twentieth world, and twenty-second national congress of Catholic doctors, on the subject of 'medicine and human rights'.

Human rights are a need in the realisation of the human person; the human person is always a realisation and a capacity; as a capacity he is a project to be fulfilled; as a realisation he is fulfilled history. And the right of the person is the right to affirm himself in history and actualise himself through his capacity.

The human right of the person as history in the field of medicine means the right to use all the advances which man has achieved hitherto in the field of medicine. The human right of the person as capacity means the always open possibility of a hope towards perfect future realisation which in the field of medicine involves constant advance to achieve harmony at every stage of life. It is to open oneself to a tendency which searches for the unity of the human being structured in the economic, social, political and cultural dimensions.

May this congress investigate these rights in the light of the Gospel so that Catholic doctors give the world at the beginning of this millennium safe ways by which to embody the doctrine of Christ in relation to medicine and thus contribute to the good of the whole of mankind!

H.E. Mons. JAVIER LOZANO BARRAGÁN,
Archbishop-Bishop Emeritus of Zacatecas,
President of the Pontifical Council for Health Pastoral Care, the Holy See.

Greeting of the President of the IFCMA

Dear Friends,

It is a great honour for me to welcome you to Rome in the name of the International Federation of Catholic Medical Associations. In the middle of the year of the Great Jubilee you have come to Rome to discuss 'medicine and the rights of man', the very meaningful subject chosen for the twentieth world congress of the IFCMA. Our meeting here in Rome, however, this year has a special value and significance which goes beyond the actual subject of this congress, however important that subject may be.

You, indeed, have come to Rome seeing it not only as a place for the congress but also as the destination of your pilgrimage. It is a city which takes us back to the Apostles and it is the home of the Pope – the visible sign of the unity of the Church and the First Defender of the Rights of Man in the whole of the world.

Like many brothers and sisters of past centuries, you have come to the tombs of the Apostles Peter and Paul to rediscover the origins of your faith, to carry out a journey of inner purification, to open yourselves to greater solidarity and fraternity. The man who lives at the beginning of the third millennium of the Christian era, perhaps even more than the pilgrims of the medieval age, needs to travel along the roads of the search for what is true and good, leading to the rediscovery of the deepest meaning of his humanity, that humanity which only Jesus Christ can reveal to us. The pilgrimage to the tombs of the Apostles thus becomes an image of the other pilgrimage, that pilgrimage which lasts for the whole of our lives.

The pilgrimage of the Jubilee can help us to rediscover respect for life, the meaning of human suffering, solidarity


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with those who accompany Christ on the cross from a position of proximity, the meaning of death, which is not a window which opens up onto the void but the real goal of man the pilgrim on this earth, the goal which opens us to the beatific vision of the countenance of God.

Profoundly inspired by these beliefs, we will be more able to understand the dilemmas and the contradictions relating to respect for the rights of man in the practical application of medicine. In many regions of the world Catholic medical doctors are certainly only a minority which at times is oppressed. We are however aware that we are an important minority – a fact of which we are proud – which is able to express a prophetic presence, especially on the basis of all the other rights of man: the right to life.

The struggle for a medicine which respects the rights of man touches upon the very heart of our Christian witness because as lay members of the Church we are called to be present at the centre of professional life and to try to change its structures and forms of behaviour, so that they can become a more transparent image of the healing love of Christ. However, without a renewal of our faith and a more intimate participation in the life of the Church, we will not have anything special to say to our patients or our colleagues.

The Jubilee offers us a unique opportunity to engage in this personal inner renewal. It calls upon us to profess our faith and at the same time to change our lives. It invites us to rediscover Christ, living in the Church, and to be committed in the temporal reality of our profession, in cultural transformations, in the free-giving of works of charity, and in social and political action.

In the name of the international federation which on the basis of a specific mandate given to us by the Church co-ordinates the work of the individual associations, I would like to thank the friends of the Italian association for the great and generous work that they have carried out in organising this congress. I would also like to thank those who work in the associations throughout the world and help Catholic medical doctors to live out their faith and bear witness to the rights of man and duties towards God amongst patients, medical colleagues and the other professionals of the world of health and health care. I would like, if it is possible, to encourage you to do even more and to invent new and more effective ways of being present in the medical profession, in teaching, in research, in a spirit of communion and of service, especially towards those people whose rights are most trampled upon. May God help and bless our efforts! In doing this we can hope with trust and confidence that our earthly pilgrimage will never become a journey which is lacking in meaning.

GIAN LUIGI GIGLI,
President of the IFCMA, the International Federation of Catholic Medical Associations.

The Greeting of the AMCI

The Association of Italian Catholic Doctors (AMCI) welcomes with enthusiasm the friendship of doctors and friends from over forty nations who have come to take part in the Congress of the Jubilee Year 2000!

It cannot be denied that this appointment organised in Rome by the three associations – the AMCI, FEAMC, and FIAMC – has a meaning and a significance which rise above what usually characterises this congress-encounter of Catholic medical doctors.

Ours is first of all the Congress of the Great Jubilee of the year 2000. Providence has bestowed upon us the moving privilege of living out this exalting cross-roads of various events – the move into the next century, the beginning of the third millennium, the holding of the Jubilee of the year 2000, and the intertwining of three congresses. Will we know how to respond to these evocative and compelling appeals?

Will we know how to be 'actors' aware of these amazing events?

And in such circumstances the subject which we proposed – 'medicine and human rights' – seems even more central and to the point. Indeed, what other century has witnessed such an irruption of a series of events of a most dramatic character which have seen man at times exalted and at times undefended and subject to violence?

In what other century has the increasingly strong distressed cry of respect for the rights of man rung out so clearly? But what rights are we talking about? It is really true that this final part of the century has been a light-giving lighthouse on the amazing journey of the human community in the face of the coming and going of the 'builders and destroyers' of human rights?

In this explosive and luminous scenario – to the great good fortune of all men – there has arisen the figure of John Paul II who has not only centred his Magisterium on the defence and the promotion of human rights but has also linked such rights to certain bases which are to be found within the Christian approach.

And the perspective of love is the direction in which the action of Christians in relation to human rights is played out. Our 'Great' Pontiff has even dedicated some encyclicals to these questions, which indeed are very dear to his heart. Thus it is that in *Centesimus Annus*(1991) he points out a series of human rights: 'the right to life, an integral part of which is the right of the child to develop in the mother's womb from the moment of conception; the right to live in a united family and in a moral environment conducive to the growth of the child's personality; the right to develop one's intelligence and freedom in seeking and knowing the truth; the right to share in the work which makes wise use of the earth's material resources, and to derive from that work the means to support oneself and one's dependants; and the right freely to establish a family, to have and rear children through the responsible exercise of one's sexuality. In a certain sense, the source and synthesis of these rights is religious freedom, understood as the right to live in the truth of one's faith and in conformity with one's transcendent dignity as a person.'(n. 47)

In essential terms they are the same rights, even if less clearly laid out, as those which are to be found in the Universal Declaration of Human Rights, rights which are indeed often remembered but which in many circumstances are deliberately forgotten about or not upheld.

Many laws have in fact denied the right to live through the enactment of permissive measures in the realm of abortion, genetic manipulation, euthanasia, and restrictions on the freedom of the individual! Have the amazing and explosive advances of technology and science in the biomedical field always been directed towards fostering the development of the individual and encouraging respect for the dignity of the person? Or at times have these not represented risks for man, who now seems to be threatened by what he produces to the point of fearing that his achievements will be turned against him? Hence, as John Paul II reminds us (*Redentor Hominis*, 1979), there is a need for this explosive development of technology to be matched by a corresponding development of the moral life and of ethics so that man 'really becomes better, more spiritually mature, more aware of the dignity and his humanity'. We Catholic doctors who have gathered together here in Rome from all over the world want to contribute to an overall positive response to the appeals of the Pope. We want with force to bear witness to the fact that medicine and its advances will always be directed towards service to man, and that solidarity and respect for love must cement relationships between all men. For this reason, we declare that we are against every assault on life, always, and in relation to every creature, and for this reason we declare that we are against every restriction on individual freedoms and thus against every form of torture and against the death penalty.

And hope, nourished by faith and matched by charity, makes us aware that we must place ourselves every day at the service of the sick, of the weakest and the least defended, and that we must listen, beginning with those, believers or otherwise, who recognise that they belong to a society based upon respect and love!

Prof. DOMENICO DI VIRGILIO
President of the Association of Italian Catholic Doctors (AMCI)

The Year 2000: The Activity of the Pontifical Council for Health Pastoral Care

Introduction

The work plan of the Pontifical Council for Health Pastoral Care, which was established at the Plenary Assembly of 1998 and subsequently approved by the Holy Father, involves fifty programmes. These programmes are organised around the Ministries of the Word, of Sanctification, and of Communion, and are entrusted to eighteen members of the Pontifical Council: its Superiors, Officials, and collaborators. Through this work plan the Pontifical Council, especially during the year of the celebration of the Jubilee Year 2000, has sought to respond in a more effective way to the mission entrusted to it by the Holy Father – to be of help to his most valuable Peterine ministry within the specific field of pastoral care in health and health care.

In the drawing up of the work plan our point of departure was the Motu Proprio *Dolentium Hominum* which established our Ministry and the Apostolic Constitution *Pastor Bonus*, and we based ourselves, with regard to the Christian meaning of suffering and life, on the Apostolic Letter *Salvifici Doloris* and the Encyclical *Evangelium Vitae*. In elaborating the practical guidelines of the general work plan much reliance was placed upon the suggestions and observations of the Apostolic Letter *Tertio Millennio Adveniente* and the *Charter for Health Care Workers*.

On the basis of these above-mentioned doctrinal premises, our Pontifical Council drew up and structured its work plan around four aspects – aims, policies, forms of action, and programmes.

The work plan of the Ministry had as its culminating point the Jubilee year. However, during the Jubilee year certain changes had to be made in order to deal with the special details connected with that event. The changes which were made involved the goals; the programmes themselves, on the other hand, remained unchanged in relation to what had been previously announced, although their form was altered.

a. General Aim

On the basis of what has just been outlined, the general aim of the Pontifical Council was established, which of course especially concerned the moment of the celebration of the Great Jubilee of the year 2000, and that aim was: 'to celebrate the incarnation of the Word according to the Bull of convocation of the Great Jubilee of the year 2000, *Incarnationis Mysterium*, to enlighten health care cultures with the Gospel, to sanctify the sick person and the environment of health in general, and to bring about the communion of pastoral care in health throughout the Church'.

b. The Action of the Pontifical Council

At a practical and concrete level, in order to achieve the above-mentioned goals in a way which was in line with its own specific objectives, in relation to the ministry of the Word (which involved eleven programmes) our Pontifical Council established that its aim was: 'to celebrate the incarnation of the Word so as to *enlighten* health care cultures with the Gospel through the Jubilee signs of pilgrimage, the Porta Santa, and indulgence.

In relation to the ministry of sanctification, which includes seven programmes, our Ministry decided that its aim was: 'to celebrate the incarnation of the Word so as to *sanctify* the sick person and in general the world of health and health care through the Jubilee signs of pilgrimage, the Porta Santa, and indulgence'.

In relation to the ministry of communion, with its twenty-nine programmes which have to be implemented, our Ministry established that its aim was 'to celebrate the incarnation of the Word so as to bring about *solidarity-inspired* communion in relation to the sick and to health care workers throughout the Church through the Jubilee signs of pilgrimage, the Porta Santa, and indulgence'.

In order to achieve the goals which the Pontifical Council established for the ministry of the Word the following initiatives were engaged in and promoted: an attempt was made to communicate the meaning of life and of suffering, and the meaning of nature and its manipulation, by explaining such meanings, spreading them, and making them reach everybody – and in particular the bishops who are responsible for pastoral care in health within their bishops' conferences. In this undertaking, the celebration of the fifteenth international conference, the publication of the journal *Dolentium Hominum*, and the participation at various conferences, seminars and meetings by the Superiors and Officials of the Ministry etc., were of great relevance.

With respect to the evangelisation of faculties of medicine, the Pontifical Council sought to maintain and develop contacts with the most important Catholic faculties of medicine, of pharmacy or of law, with a view to promoting suitable future courses. The other programmes which were implemented by the Pontifical Council in the area of the Word with intensely-felt commitment were connected with the following areas: publications, the World Health Organisation, the book on the pastoral care of drug-addicts, pastoral guidance in health, conferences, the international conference, research, teaching centres, and dossiers.

As has already been observed in this report, in relation to the ministry of sanctification the Pontifical Council drew up seven programmes of notable importance: baptism, the anointing of the sick, other sacraments, the book of prayer and the sacraments, the World Day of the Sick, and the 'Intention' of the Apostolate of Prayer.

In order to achieve its aims in relation to the ministry of communion in 2000, our Pontifical council established thirty-two programmes designed to strengthen or achieve this solidarity-inspired communion. These programmes revolved around the anointing of the sick, Catholic medical doctors and nurses, and support for their associations, especially at an international level. In this project, which aims at the unification of pastoral care in health throughout the world, the creation of an international union of Catholic hospital chaplains is also of importance, as indeed is the union of Catholic hospitals, the union of those members of religious orders who work in hospitals, and the union of the bishops responsible for pastoral care in health within their respective bishops' conferences. In addition, an attempt was made to intensify the pastoral action carried out in relation to Catholic health care voluntary workers and to increase the number of patients' associations. Of the various programmes belonging to the sector of sanctification special reference should be made to: the centres of bioethics and attempts to achieve their unification; the organ-

isation and the celebration of the World Day of the Sick; the universal right to health; the Christian communication of goods; emergency diseases (AIDS and leprosy); drugs; inter-Ministerial relations; the bishops responsible for pastoral care in health; papal Nunciatures; *ad limina* visits; the participation and representation of the Pontifical Council at conferences and meetings outside Rome and abroad; pastoral visits and journeys etc. In the work plan emphasis was also placed on the internal administrative programmes of the Ministry which form a part of the sector of communion, that is to say: the secretariat, the administration, the archives room, the provision of printed material, and the cataloguing and archiving of documents and publications.

The above mentioned programmes were implemented with keenly-felt commitment on the part of all the members of the Ministry. The results gave rise to great satisfaction and confirmed that the work plan was fully in harmony with the goals established for 2000.

Given this, we would like here to list in a more detailed way a number of salient aspects of the activity of the Pontifical Council in the year 2000.

1. The Celebration of the Jubilee of the Sick and Health Care Workers

Within the framework of the ministry of sanctification we encounter a very important programme of the activities of the Pontifical Council – the annual celebration of the World Day of the Sick.

During the Jubilee year this was solemnly celebrated at Rome in the form of the 'Jubilee of the Sick and Health Care Workers'.

Four salient elements marked the various celebratory events. These were: prayer, study, festive gatherings, and visits to a number of places closely linked to the Jubilee event.

1) *Prayer*. More than 20,000 pilgrims – infirm people and health care workers – arrived from all over the world to take part in the various events and celebrations which had been prepared with great care by the Pontifical Council for Health Pastoral Care. The moments of intense spirituality were the following: the celebration of the Holy Mass of welcome on 10 February at the basilica of 'St. Paul's Outside the Walls', presided over by H.E. Mons. Javier Lozano, the President of our Ministry; the Marian procession "Aux Flumbeaux" along the Via della Conciliazione, which was led by the President of the Pontifical Council and finished in St. Peter's Square where it received the blessing of the Holy Father; and the pious act of the Via Crucis to the Coliseum.

The most significant celebration was without doubt the solemn celebration of the Eucharist held on Friday 11 February in memory of the Blessed Virgin of Lourdes. This celebration was presided over by the Holy Father in St. Peter's Square, a place which became for the event almost a great and open air place of passage.

Next to the altar there was the white statue of the Madonna of Lourdes. There were also fifty concelebrants in white chasubles, amongst whom His Eminence Car-

dinal Etchegaray, President of the Committee for the Great Jubilee of the Year 2000, with the Secretary of the same Committee, Archbishop Crescenzio Sepe; H.E. Mons. J. Lozano Barragán, President of the Pontifical Council for Health Pastoral Care, accompanied by the Secretary of the same Ministry, H.E. Mons. José Redrado, and its Under-Secretary, Rev. Felice Ruffini M.O.; and forty-seven archbishops and bishops responsible for pastoral care in health in their respective bishops' conferences. Three hundred and fifty priests involved in the world of pastoral care in health throughout the world also concelebrated in the presence of civil and military authorities.

The celebration of the Eucharist, in which over thirty thousand pilgrims took part (of whom 2,400 were infirm people and had to sit in wheel-chairs), was solemn and intense. 1,700 disabled people unable to walk were seated in front of the statues of St. Peter and St. Paul in the square. In addition, there were the family relatives of sick or infirm people, medical doctors, paramedical staff, voluntary workers, those who accompany the sick and the infirm, and members of male and female religious orders.

In addressing the sick and disabled and health care workers, in his homily the Holy Father pronounced the following most valuable words: 'The Jubilee is an experience of a very special Visitation. In making himself man, the Son of God came to visit every person and made himself 'the Door' for everybody: the Door of life, the Door of salvation. Man must enter through this door if he wants to find salvation. Each and every person is invited to cross this threshold... The Church enters the new millennium clasping to her heart the Gospel of suffering, which is the good news of redemption of salvation. Sick brothers and sisters, you are the special witnesses to this Gospel. The third millennium expects this witness from suffering Christians. It also expects such witness from you, workers of pastoral care in health, who, with different roles, at the side of sick people carry out a mission which is both meaningful and appreciated, indeed very appreciated'.

The administration of the sacrament of the anointing of the sick was also a very moving moment. The Holy Father personally administered this sacrament to ten sick people. It was also administered to another ninety sick people by bishops and priests, among whom the President of the Pontifical Council, H.E. Mons. Lozano, H.E. Mons. Redrado O.H., and Rev. P. Felice Riffini M.I., respectively the Secretary and Under-Secretary of the Pontifical Council.

The celebration of this special day terminated with the solemn blessing of all the participants, and especially the sick and infirm.

2. *Study*. On 9-10 February a conference of bishops responsible for pastoral care in health in their respective bishops' conferences, and the Catholic associations of health care workers, was held in the New Hall of the Synod in the Vatican. During these two days of study, in different rooms, thought was addressed both in the teaching conferences and in the group forums to the identity of Catholic health care workers given the challenges with which they are faced by the third millennium. Over two hundred participants were present, and they represented all the continents of the world. The President of our Ministry, H.E. Mons. Javier Lozano, introduced the days of study and provided two instructive papers. One was directed towards bishops responsible for pastoral health in care and was on the subject of 'pastoral care in health', and the other was addressed to Catholic medical doctors and was on 'the identity of the Catholic medical doctor'. In addition to the President of the Pontifical Council, the following gave papers: H.E. Mons. Redrado O.H, Secretary of the

Ministry, who spoke on 'the programme of the Ministry: the work plan'; Dr. Gian Luigi Gigli, President of the International Federation of Catholic Medical Associations (FIAMC), whose subject was 'the challenges of Catholic medical doctors and the third millennium'; Rev. Joseph Joblin, the Ecclesiastical Assistant to the International Committee of Nurses and Medical-Social Assistants (CICIAMS), who gave a paper on 'the identity of the Catholic nurse'; Miss An Verlinde, General Secretary of the CICIAMS, who addressed the assembly on 'challenges for the third millennium'; Rev. Felice Ruffini, Under-Secretary of the Pontifical Council, who spoke about 'the identity of the Catholic pharmacist'; and Prof. Alain Lejeune, President of the International Federation of Catholic Pharmacists (FIUPC), who gave a paper on 'the challenges of the third millennium'.

3. *Festive events*. Two splendid festive events with a strong spiritual meaning also took place. On the evening of 11 February, in St. Peter's Square, at the end of the torchlight procession, an 'evening of light and sounds' was enjoyed, and on 12 February a 'day of joy and hope' was held in the Paul VI Hall of the Vatican, made up of the witness of a number of people, amongst whom artists and representatives of the world of sport, who through their suffering had encountered Christ – their joy and hope. The infirm people were the real protagonists of this festive event.

4. *Visits*. On 12 February in the morning visits organised for groups based on the respective languages spoken took place at the basilicas of the Jubilee – Santa Maria Maggiore, San Giovanni in Laterano, and Santa Croce in Gerusalemme. In addition, the national Churches arranged a number of visits for their own pilgrims.

The various festive events and celebrations were broadcast by television throughout the world by satellite. Especial emphasis should be placed on the link with the Marian sanctuaries where the World Day of the Sick has been held in the past or where it will be celebrated in the near future.

The celebration of the World Day of the Sick terminated on 13 February with the holding of Holy Masses in the places of welcome.

2. Inter-Ministerial Meetings

Within the framework of the ministry of Communion, the Pontifical Council maintained strong contacts with the other Ministries of the Roman Curia, and took part in a number of inter-Ministerial meetings:

– at the Pontifical Council 'Justice and Peace'. Rev. Don Antonio Soto, an Official of the Ministry, took part on 8 April in the inter-Ministerial meeting dedicated to the preparations for the World Day of Peace (2001);

– at the Pontifical Council for Culture. On 8 June, Rev. Don Krzysztof Nykiel, an Official of the Ministry, took part in the inter-Ministerial meeting on the subject 'the science-faith dialogue: new perspectives'.

3. Participation and Representation at Congresses and Conferences

Another programme of the ministry of the Word was the participation and representation of the Pontifical Council at various congresses and conferences. Throughout the year 2000 Superiors and Officials of the Pontifical Council took part in such meetings.

JANUARY

– On 24-29 January, at Geneva, Rev. Mons. Jean-Marie Mpendawatu was a member of the delegation of the Holy See to the meeting of the executive committee of the World Health Organisation.

FEBRUARY

– On 14 February, in the Vatican, H.E. Mons. Javier Lozano was a participant at the Day dedicated to commemorating the Encyclical *Evangelium Vitae*, an event promoted by the Pontifical Academy for Life.

– On 17 February, in Rome, the President of the Ministry, H.E. Mons. Lozano Barragán, presided over the celebration of the Eucharist which was held at the end of the symposium on Mexican Catholic martyrs. He emphasised that the symposium was to be located within the context of the Jubilee celebrations. The President also recalled that martyrs are a perennial sign of the truth of Christian love.

– On 23 February, in Rome, the Official of the Pontifical Council, Rev. Mons. Jean Marie Mpendawatu, took part in the meeting organised by the 'Child Jesus' hospital on the question of international action to help children afflicted with AIDS in Romania.

– On 25-27 February, in the Vatican, H.E. Mons. Lozano and H.E. Mons. Redrado took part in the international conference on 'the implementation of the Ecumenical Vatican Council II' which had been organised by the Historical Theological Commission of the Jubilee.

MARCH

– On 3 March, in Frosinone, in response to an invitation extended to him by by H.E. Mons. Salvatore Boccacio, the Bishop of Frosinone, the President of the Pontifical Council took part in a seminar organised around the subject of 'the tragedy of illness and hope of relief. From the loneliness of the sick person to participation in his pain'. The President of the Pontifical Council gave a paper entitled 'hope and the sick person: theological perspectives'.

– On 28 March, in the basilica of St. Peter's, the President of the Ministry, H.E. Mons. Lozano, presided over a concelebration of the Eucharist at the opening of the seventh national congress of the 'College of Teachers of Dentistry'. For those taking part this was also an opportunity to observe the requirements of the Jubilee.

APRIL

– On 4-6 March, in Mexico City, accompanied by the Official of the Ministry, Rev. Don Krzysztof Nykiel, H.E. Mons. Javier Lozano was a participant at the fourth national congress and the third international congress of religious institutions at the service of health. This congress had been organised by the Archdiocesan Commission for Pastoral Care in Health of the Archdiocese of Mexico and the Congregation of the Franciscan Religious of the Immaculate Conception, A.R., on the subject: 'curing the body; healing the soul. Towards the third millennium'. The President gave a paper on the subject: 'curing the body and healing the soul'.

– On 6-7 April, in Mexico City, the President of the Ministry took part in the 'Second Annual Pan-American Catholic Health Care Dialogue', which had been organised by the Pontifical Council for Health Pastoral Care and the Archdiocese of New York on the subject: 'A Jubilee celebration for the whole of humanity', and gave a paper on the subject: 'the celebration of the Jubilee and the sick person'. Rev.

Don Krzysztof Nykiel, an Official of the Pontifical Council, also took part in the deliberations of this conference.

– On 7 April, in Rome, the Secretary of the Ministry, H.E. Mons. Redrado, presided over the concelebration of the Eucharist at the time of the national conference on 'answers of Italian religious life to disabled people', and gave a homily on the subject matter of the conference.

– On 27 April, in Rome, Rev. Don Krzystof Nykiel, an Official of the Ministry, took part as a representative of the Pontifical Council in the conference organised by the Faculty of Theology and the Pastoral Pontifical Institute 'Redemptor Hominis' of the Pontifical Lateran University, together with the local committee for the XLVII International Eucharistic Congress of the Diocese of Rome, on the subject: 'Jesus Christ. The only saviour of the world; bread for a new life'.

MAY

– On 10 May, in Genzano near Rome, the Official of the Pontifical Council, Rev. Don. Krzysztof Nykiel, took part in the first International Workshop on the Humanitarian Initiatives and the Experience of Co-operation of Non-Governmental Organisations (NGOs) and Non-Profit Organisations (NPOs), and gave a paper on 'the activity of the Pontifical Council for Health Pastoral Care'.

– On 15-20 May, in Geneva, the President of the Ministry, H.E. J. Lozano, took part, as head of the delegation of the Holy See, in the fifty-third session of the World Health Assembly, and gave a paper on the concept of health in the Magisterium of the Church. Rev. Mons. Jean-Marie Mpendawatu, an Official of the Pontifical Council, was also a member of this delegation.

– On 22 May, in Rome, H.E. Mons. Lozano inaugurated the meeting of the governing council of the Pontifical Academy for Life, and extended greetings to all the participants at this meeting.

JUNE

– On 1 June, in Naples, in response to an invitation extended to him by H.E. Mons. Antonio Riboldi, the Bishop Emeritus of Acerra, the President of the Ministry took part in an international conference on the subject of 'the right of the child to health' and gave a paper on 'the right of the child to the defence of his health'.

– On 12-15 May, in Itaici, Brazil, H.E. Mons. Lozano took part in a conference organised by the National Bishops' Conference of Brazil on the subject: 'AIDS e desafios para a igraja do Brasil'. The President gave a paper on 'AIDS, ecclesial reality and pontifical perspectives'.

JULY

– On 12-15, in Kuala Lumpur (Malaysia), H.E. Mons Lozano and H.E. Mons. Redrado took part in the twelfth Congress of the Asian Federation of Catholic Medical Associations, organised by the Associations of Malaysian Catholic Doctors, on the subject: 'health challenges in Asia in the new millennium'. The President gave a paper on 'healing in the Gospels'.

AUGUST

– On 20 August, in Zamorra (Mexico), H.E. Mons. Lozano, in the presence of two hundred medical doctors and other health care workers, held a conference on the subject of 'the identity of the Catholic medical doctor'.

SEPTEMBER

– On 5 September, in Chieti, the Secretary of the Ministry, H.E. Mons. Redrado, presided over the deliberations of the international congress on 'the ethical questions and issues of clinical experiments' which had been organised by the archdiocese of Chieti-Vasto within the framework of the Jubilee of university teachers. In addition, he gave a paper on 'research and respect for human life'.

– On 6 September, in Rome, the Secretary of the Ministry, H.E. Mons. Redrado, was a participant at the Jubilee of university teachers and gave a paper which introduced the deliberations on the subject. The paper was entitled: 'the path of the terminally ill and death'.

– On 15 September, in Rome, H.E. Mons. Redrado presided over a celebration of the Eucharist on the occasion of the course of permanent training organised by the Congregation of the Children of the Immaculate Conception, and gave a homily during the religious service.

– On 25-29 September, in Caltanisetta (Sicily), accompanied by Rev. Antonio Soto, an Official of the Ministry, H.E. Mons. Lozano was a participant at the Third World Congress on Drug Prevention, organised by the 'Casa Famiglia Rosetta' Association, on the subject: 'new frontiers for the prevention of drugs and criminality for young people and the community'. The President gave a paper on: 'the ethical and moral position of the Holy See in relation to drugs'.

– On 25-27 September, in Madrid, H.E. Mons. Redrado took part in the Twenty-fifth National Day of Pastoral Care in Health, and gave a paper on the subject: 'the spiritual needs of the sick child and his pastoral care'.

OCTOBER

– On 5-8 October, in Pittsburgh, the President of the Pontifical Council, H.E. Mons. Lozano, took part in the annual meeting of the Association of Catholic Medical Doctors of Pittsburgh, and gave a paper which bore the title: 'the medical doctor and his vocation in relation to the mission of the Church'. In addition, the President presided over a solemn celebration of the Eucharist with the rite of the entrusting of the Catholic medical doctors of the United States of America to the Immaculate Heart of the Virgin Mary.

– On 10 September, in Rome, H.E. Mons. Redrado presided over a prayer meeting organised by the Pontifical University 'Regina Apostolorum', and gave a paper on the subject: 'witnesses and servants to hope'.

– On 11-13 September, in the Vatican, the Official of the Ministry, Rev. Don Krzysztof Nykiel, represented the Ministry at the International Pastoral Theological Congress on 'children: the spring of the family and of society', organised by the Pontifical Council for the Family.

NOVEMBER

On 7 November, in Rome, in response to an invitation extended to him by Dr. Agostino Falconi, the President of the Organ Transplant Association of the Marches, H.E. Mons. Lozano presided over a celebration of the Eucharist on the occasion of the Jubilee of that association, and gave a homily during the ceremony.

– On 7-9 November, in Quito, the Official of the Ministry, Rev. Mons. Jean-Marie Mpendawatu, took part as an observer of the Holy See in the Seventh Session of the International Committee on Bioethics of UNESCO.

– On 9 November, in Rome, H.E. Mons. Redrado took part in the ceremony of the inauguration of the academic year of the Catholic University of the Sacred Heart 'A Gemelli'.

– On 9-11 November, in Svit, accompanied by Rev. Don Krzysztof Nykiel, an Official of the Ministry, H.E. Mons, J. Lozano was a participant at the Ninth International Symposium organised by the Faculty of Theology of the University of Tirnava on the subject: 'the new evangelisation', and gave a paper on 'the identity of the Catholic medical doctor'. On 11 November the President of the Pontifical Council, H.E. Mons. Lozano, also took part in the meeting of the European Federation of Catholic Medical Doctors at

Bratislava, and the next day presided over a celebration of the Eucharist for them and gave a homily of relevance to their interests.

– On 25 November, in Padua, the President of the Pontifical Council, H.E. Mons. Lozano, was a participant at the international conference organised by the University College of Missionary Doctors on the occasion of the fiftieth anniversary of its foundation, and gave a paper on the subject of 'Africa in the year 2000: health for everybody'.

– On 28 November, in Fatima, Rev. Don Antonio Soto, an Official of the Ministry, took part in the deliberations of Fifteenth National Congress on Pastoral Care in Health of Portugal, and gave a paper on: 'health and solidarity in the Jubilee year 2000'.

DECEMBER

– On 6-8 December, in El Alto, the President of the Ministry, H.E. Mons. Lozano, was one of the participants at the National Meeting of Pastoral Care in Health in Bolivia, and gave two papers – one on 'bioethics' and one on 'pastoral care in health in Bolivia'.

4. Pastoral Visits and Journeys

Through pastoral visits and journeys the Pontifical Council sought to be present in a concrete way in the world of health and suffering so as to help in the sanctification of the sick person and of the world of health more generally.

MARCH

– On 26 March, H.E. Mons. Lozano, in response to an invitation extended to him by the Primate of Poland, His Eminence Cardinal Josef Glemp, took part in the consecration of the Church dedicated to Our Lady of Guadalupe situated in Laski (near Warsaw), and spoke on the anthropological significance of the painting of the Madonna of Guadalupe. In addition, he visited the largest Catholic centre for the blind in the country. The President was accompanied by Rev. Antonio Soto, an Official of the Ministry.

5. The Seminar Day on Hansen's Disease

On the occasion of the 'World Day of Leprosy 2000', a 'Seminar Day on Hansen's Disease' was held in the Vatican in the New Hall of the Synod. This event was organised by the Pontifical Council for Health Pastoral Care and the Italian Association of the Friends of Raoul Follereau, and bore the title: 'Hansen's disease: reality and prospects'. This international day witnessed the participation of about a thousand people who had come from all the continents of the world, and also witnessed the presence of ecclesiastical and civil authorities. At the inauguration were present His Eminence Cardinal Angelo Sodano, the Secretary of State of the Holy See, H.E. Mons. J. Lozano, President of the Pontifical Council for Health Pastoral Care, H.E. Mons. Redrado, the Secretary

of our Ministry, Rosy Bindi, ex-Minister of Health of Italy, and Prof. Henry Kiniffo, the President of the Raoul Follereau Association of Benin.

The President of the AIFO, Dr. Enzo Zecchini, made an opening speech of greeting to the participants.

During the deliberations of the seminar day attention was dedicated to such subjects as: 'poverty, development and health'; 'leprosy in the world: analysis of the situation and new scientific developments'; 'the role of the member associations of the International Federation – historical development and future prospects'; 'the figure of Raoul Follereau – the Luxembourg Raoul Follereau Association'; 'the figure of Father Damian – the Belgian Damian Foundation'; 'disability and leprosy'; 'journalists and those afflicted by leprosy'; and 'leprosy – a word for marginalisation'.

The seminar day was ended with a prayer presided over by the President of the Ministry, H.E. Mons. J. Lozano.

At the Angelus of Sunday 16 January, the Holy Father gave a cordial greeting to those taking part in the seminar day and expressed his appreciation of their work in favour of people afflicted by leprosy – who at the present time in the world number about fifteen million – and expressed the wish and hope that the year 2000 would mark a decisive step forward in the healing and saving of our brothers and sisters who are afflicted by leprosy and would also provoke in the spirit of Christians a generous readiness to help all of our brothers and sisters who are in need. On this theme, the Holy Father recalled that 'Hansen's disease, in fact, is curable with medicines and drugs which are relatively cheap but which are often not available to those who are afflicted by this disease because of the state of great poverty in which they find themselves. In essential terms, the most dangerous 'leprosy' is acute poverty which should be fought at an economic level, and even prior to that with a deep conversion from the logic of selfishness to the logic of solidarity.'

6. The Joint Meeting of Delegates of the Continents of the World and the Group of Experts of the IACHCI

Within the context of programming the unification of pastoral care in health throughout the world, the Pontifical Council promoted and organised, following the international symposium of the International Association of Catholic Health Care Institutions (IACHCI) which was held in the Vatican (at the Nova Domus Sanctae Marthe) on 1-3 July 1999 on the subject 'the Catholic health care institutions as witness of the Church', a joint meeting of delegates from the continents of the world and a group of experts. This took place in the Vatican on 26-28 May 2000.

About twenty-five people took part in the meeting which was divided into two days of study and reflection. The President of the Ministry, H.E. Mons. Javier Lozano, opened the deliberations of the meeting with a message of greeting, which was followed by a similar speech by the Director of the IACHCI, Fra Pierluigi Marchesi O.H.. During these two days the strategies to be adopted after the symposium of July 1999 were discussed. The representatives of the continents of the planet described all the activities which they had promoted, or which they planned, for the growth and development of the IACHCI in their respective continents. Unanimously, the importance of a body such as the IACHCI within the Church was upheld. Amongst the goals which the participants set themselves was the organisation of a new symposium in the year 2000.

The President of the Pontifical Council, H.E. Mons. Javier Lozano, speaking at the end of the deliberations thanked everyone for the work which had been carried out and made a concluding summary of what had been achieved.

7. The Study Seminar on 'the Sacraments in Pastoral Care in Health'

In the work plan of the Pontifical Council for the ministry of Sanctification there are three programmes which relate to the sacraments within the context of pastoral care in health, and more specifically: baptism, the anointing of the sick, and the other sacraments.

These 'programmes' have as their goal the sanctification of the infirm person and of the world of health and health care more generally.

Of the many initiatives taken in this sphere, the Pontifical Council promoted and organised on 2-3 June 2000, together with the Pastoral Institute 'Redemptor Hominis' of the Pontifical Lateran University, a study seminar on 'the sacraments in pastoral care in health' which was addressed to theologians, experts and health care workers. During this seminar an attempt was made to bring out and investigate the questions and issues of the subject from their various angles: whether socio-cultural, anthropological, or connected with dogmatic theology or pastoral theology.

The seminar dwelt upon two main areas of concern:

– the sacraments in relation to health and illness; and

– health and illness as favourable and meaningful sites for the celebration of the sacraments.

The two days of study gave rise to observations and a number of guidelines about the meaning and importance of the sacraments and their relevance in pastoral care in health.

In particular, during the deliberations of the seminar the participants placed emphasis on the need to organise another study seminar, this time on the subject of the anointing of the sick.

For this reason, given the importance and sensitivity of this subject, the Pontifical Council approached the Congregation for the Doctrine of the Faith, requesting its authoritative participation at such a study seminar, with a paper to be given by a qualified representative of that Congregation,

The Congregation for the Doctrine of the Faith assured the Pontifical Council of its co-operation, not least in the form of a delegate who would be present during the planning stage of the above mentioned seminar. The letter also communicated the fact that the Congregation for the Doctrine of the Faith was presently examining the question of the theological definition of doctrine in relation to the ministry of the anointing of the sick.

The year 2002 was proposed as a date for the next seminar.

8. The Fifteenth International Conference

On 16-18 November, in the Vatican (in the New Hall of the Synod), the fifteenth international conference was held. Promoted and organised by the Pontifical Council, its subject was: 'health and society'. The annual international conference is very important for the life of the Ministry, not least because it forms a part of the programmes of the ministry of the Word whose goal during the Jubilee year of 2000 was to celebrate the Word made flesh in order to enlighten health care cultures with the Gospel.

About six hundred participants from sixty-six countries took part in this international conference, as well as fifteen ambassadors to the Holy See, a representative of the World Health Organisation (WHO), three Ministers of Health, and two hundred and fifty medical doctors who represented their respective Catholic health care federations and associations. Those who gave papers at the international conference included two Cardinals, two bishops, as well as authoritative researchers, scientists, and scholars from the humanistic disciplines, the social sciences, the biomedical sciences, and the discipline of pastoral theology.

The President of the Ministry, S.E. Mons. Lozano, made an introductory speech, and His Eminence Cardinal Angelini, Emeritus President of the Ministry, made a speech of greeting to the participants.

The general subject of 'health and society' was examined by a number of speakers in the light of the Word of God and theology in order to bring out and illuminate present-day technological challenges and moral aspects in order to achieve the humanisation of medicine within a society which is increasingly globalised.

During the deliberations of the conference the following subjects were discussed and analysed: the new frontiers of medical technology, the new places of care and treatment, hospitals and the homes of patients, the new health care workers, the new services offered to sick people, the new kinds of sick people and new emerging diseases such as Alzheimer's, AIDS, and those brought about by drug abuse, etc., medicine and cultural changes, the contemporary questions of moral theology, the prospects opened up by modern medicine for inter-religious dialogue with Judaism, Islam, Hinduism, and Buddhism, and the training of health care workers, chaplains, and voluntary workers.

The participants at the international conference were received by the Holy Father at an audience given in the New Hall of the Synod. In his authoritative speech the Pope emphasised amongst other things 'that the role of health care workers has the characteristics of a vocation: to encounter the sick person means to encounter thereby the suffering person and not merely to treat a sick body'.

The Holy Father also emphasised the concept of health when he stated that 'health, far from something to be identified with the mere absence of illness, is a tendency towards greater harmony and healthy balance at the physical, spiritual and social level. From this perspective, the person himself is called to mobilise all his available energies in order to realise his vocation and the good of others'.

9. The Inter-Continental Meeting on AIDS

Another significant and important moment in the activities of the Ministry towards the end of the year 2000 – and once again an event which took place within the framework of the ministry of Communion – was the inter-continental meeting on AIDS which was held in the Vatican (at the Nuova Domus Sanctae Marthae) from 30 November to 1 December.

H.E. Javier Lozano, President of the Pontifical Council, began the deliberations of the meeting with a speech of greeting and a few words of introduction in relation to the World Day of AIDS.

On the first day of this meeting, H.E. Mons. Redrado outlined and described the work which had been carried out during the period 1999-2000. The AIDS library and archive were then referred to and discussed. The press conference on the World Day of AIDS, which was held in the Vatican press room, was also of marked importance, as was the presentation of the project for a vademecum on AIDS which was made by the Secretary of the Ministry, H.E. Mons. Redrado. Reference should also be made to the papers on the realities, problems and proposals of the local Churches in relation to AIDS in the continents of Africa, America, Asia and Europe.

The second day was entirely devoted to the visit to two institutions where the problem of AIDS is present – the 'Baby Jesus' hospital and Rebbibia prison. In these two places round table conferences were held which also involved the participation of those in charge of these institutions.

The deliberations ended with the wish and the hope that those afflicted by AIDS would be accompanied by the solidarity of the Church and by the fraternal generosity of men and women of good will, following the example of the Good Samaritan, and that they would be helped with suitable instruments and measures and would be taken care of until their last moment.

10. Monthly Prayer with and for Sick People During the Jubilee Year

At the beginning of the Jubilee year the Holy Father expressed the wish that there would be special moments of prayer said by sick people and other visitors in the basilica of Santa Maria Maggiore in Rome during the whole of the year 2000 with a view to obtaining the Jubilee indulgence. The last Tuesday of every month was chosen as the date of the prayer meetings with and for sick people. In order to involve all the countries of the world special dates were chosen for each geographical region and eminent religious authorities were invited to preside over each prayer meeting.

At each of these moments of prayer a passage from the Gospels which bore on the meeting was read out, and there then followed a few thoughts on the subject which were expressed by the ministrant. Subsequently, prayer took place in front of the displayed most holy sacrament and ended with the blessing of those present and a prayer to the Holy Virgin 'Salus Infirmorum' which had been especially written by the Holy Father John Paul II for this occasion.

Each month, for each geographical area, there was an intense participation on the part of sick people, the disabled, and those who accompanied them. This was also true of the various organisations involved in helping and looking after the infirm, such as UNITALSI, the Don Guanella Institute, the Cottolengo, and others. They thus met the precisely expressed wishes of His Holiness the Pope.

11. Publications

Publishing activity is a part of the programmes of the ministry of the Word. First of all the attention of the reader should be directed to the journal of the Ministry, *Dolentium Hominum. The Church and Health in the World*, which has been published regularly. It is offered to our readers in four editions: Italian, Spanish, French, and English. One of the issues always contains the acts of the international conference organised by the Pontifical Council. During the year 2000 the complete acts of the meeting on Aids, of the study seminar on the identity of the Catholic chaplain in pastoral care in health and health care, of the seminar day on Hansen's disease, and the study seminar on the sacraments in pastoral care in health, were all published in this journal.

The Charter for Health Care Workers, which was published under the auspices of the Pontifical Council in Italian in 1994, has since been published in various countries in the following languages: Spanish, English, French, German, Dutch, Polish, Portuguese, Russian, Czech, and Romanian. After receiving the *nulla osta* of the Pontifical Council, editions are also being prepared in Hungarian and Lithuanian. Translations of the work are also now being prepared for publication in Madagascan, Albanian, and Thai.

Four editions in Spanish (two in Mexico, one in Peru, and one in Colombia) have been published of the book by the President of the Pontifical Council, H.E. Mons. Lozano, entitled 'Theology and Medicine'. An edition in Italian is also being prepared. A book entitled 'Women and the Good Samaritan', the outcome of the first meeting, at the level of the Universal Church, on the presence and activity of consecrated women in the world of health and health care, has been published in Italian. This is the first and comprehensive support for the initial training of female candidates for religious life who are being prepared for the ministry of caring for those who suffer.

12. Conclusion

The above mentioned programmes of the work plan of this Pontifical Council directly and intensely involved the Superiors, the Officials, and the internal and external staff of the Ministry. In the Pontifical Council building itself activity was very intense. Meetings were held in order to prepare the ground for the conferences and congresses organised by the Pontifical Council, the meetings between representatives of Ministries of the Roman Curia and other experts within the framework of various study groups held to study the questions of drugs, AIDS, leprosy, the IACHCI, guidance for pastoral care in health, the book on prayer and the sacraments, and the prayer meetings for sick people at the basilica of Santa Maria Maggiore, etc.

Thanks to this shared commitment, it was possible to carry out many initiatives (as, indeed, has been demonstrated above). Other initiatives are still being promoted. In addition, one should not forget that during the year 2000 the epistolary correspondence of the Pontifical Council with episcopates, representatives of the Pope (and especially with those of recent appointment), with archbishops and bishops who visited Rome for reasons connected with the Jubilee or other reasons, and with priests, the members of female and male religious orders, and with health care workers, was also sustained and continued.

Rev. Don KRZYSZTOF NYKIEL
Official of the Pontifical Council for Health Pastoral Care, the Holy See