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ADDRESS OF HOMAGE TO THE HOLY FATHER

Most Holy Father,

in the context of the Great Jubilee we have gathered together to celebrate our fifteenth international conference, which this year is held on the subject 'health care and society'. In this Jubilee year we are experiencing the newness of Christ in our lives so that the contemporary relevance of his message becomes the motor and the reason for being of our existence. This alive presence of Christ has led us in this conference to address ourselves to the pressing and topical subjects connected with medicine and health in our society.

Holy Father: in the constitution 'Pastor Bonus' you entrusted to this Pontifical Council for Health Pastoral Care all those who engage in service for the infirm so that the apostolate of compassion the infirm await corresponds in ever an more effective fashion to new needs and requirements (Apostolic Constitution 'Pastor Bonus', 11. 151).

Over recent days some of these new needs and requirements have been the subject of study: we have considered the frontiers of medical technology, the new places of care and treatment, the local areas, the new health care workers, the new sick, the new emerging illnesses, the new meanings of pastoral care in health, the new moral questions, inter-religious dialogue in these areas, and the training of health care workers, chaplains and voluntary workers.

Most Holy Father: it is specifically in relation to these complex questions that we most have need of your thought, so that you can enlighten us and guide us with the example of Christ, the divine physician of bodies and souls.

We humbly ask Your Holiness for your authoritative words and we beseech the Apostolic Blessing.

H.E. JAVIER LOZANO BARRAGÁN,
President of the Pontifical Council for Health Pastoral Care, the Holy See.

ADDRESS BY THE HOLY FATHER

Medicine Must Serve Man's Total Wellbeing

Venerable brothers in the Episcopate and the Priesthood,

Distinguished Ladies and Gentleman,

1. I am pleased with this meeting which allows me to bring you my greetings on the occasion of the 15th international congress organized by the Pontifical Council for Health Pastoral Care. I extend a particular greeting to the President of the Pontifical Council, Archbishop Javier Lozano Barragán, whom I thank for the sentiments he has expressed on behalf of everyone present. I express my deep satisfaction to the organizers, as well as to the distinguished scholars, scientists, researchers and experts who have wished to honour this conference with their presence and professional contribution.

The days of the congress, which this year is discussing the important and complex theme "Health Care and Society", will help you to examine the new biomedical technologies and the difficult questions posed to the world of health care by the profound social changes now taking place. Your meeting has encouraged a fruitful dialogue and a cultural and religious exchange between qualified workers in the health society.

Health cannot be limited to physical well-being

2. The theme of the congress highlights a reality of great importance and one in continual transition, which should be carefully analyzed. In particular, you have raised the problem of the relationship between society and institutions on the one hand and those who manage the means of health care, on the other. Profound changes are affecting the traditional structures of a society that is increasingly globalized and has difficulty in relating to the individual, while medicine is involved in developing diagnostic and therapeutic methods which are ever more complex and effective, but often available only to limited groups of people. Today the role of environmental causality in the genesis of certain diseases is also well known because of social pressure and the powerful impact of technology on individuals. Therefore, it is necessary to recover certain criteria of ethical and anthropological discernment, which make it possible to judge whether the decisions taken by medicine and health care are really suited to the human being they must serve.

3. But prior to that, medicine must answer the question about the very essence of its mission. One wonders whether medical care finds its *raison d'être* in preventing illness and, when possible, in overcoming it, or whether one must accept every request for physical intervention because it is technically possible. The question becomes even broader if one considers the concept of health itself. Today an idea of health restricted solely to physiological well-being and the absence of suffering is commonly recognized as insufficient. As I wrote in my Message for the World Day of the Sick in this Jubilee Year, "health, based on an anthropology that respects the whole person, far from being identified with the mere absence of illness, strives to achieve a fuller harmony and healthy balance on the physical, psychological, spiritual and social level. In this perspective, the person himself is called to mobilize all his available energies to fulfil his own vocation and the good of others" (n. 13). This is a complex concept of health, which is more consonant with today's sensibilities and is aware of the balance and harmony of the person as a whole: you do well to focus your attention on this issue.

The question I asked above is important because the profile of future health-care workers depends on it, as does the style of the health centres which one intends to establish and the very model of medicine which we want to guide us: medicine at the service of the individual's total well-being, or, on the contrary, medicine marked by technical and organizational efficiency. You know that a medical science on the wrong track would soon endanger not only the life of the individual, but society itself. Medicine that aimed primarily at increasing its knowledge for the sake of its own technological efficiency would betray its original

ethos, opening the door to harmful developments. Only by serving man's total wellbeing can medicine contribute to his progress and happiness, and not become an instrument of manipulation and death.

4. Distinguished biomedical scientists, in your activities you know well how to respect the methodological and hermeneutical laws proper to scientific research. You are convinced that they are not an arbitrary burden, but an indispensable help that guarantees the reliability and communicability of the results obtained. May you always recognize with equal care the ethical norms at whose centre lies the human being with his dignity as a person: respect for his right to be born, to live and to die in a worthy manner is the basic imperative which must always inspire medical practice. Do everything you can to sensitize the social community, the national health-care systems and their leaders, so that the considerable resources directed to research and technical applications will always have the total service of life as their goal.

Yes, the centre of attention and care both of the health-care system and of society must always be the person, considered in the concrete circumstances of his family, work, social context and geographical area. Reaching out to a sick person thus means reaching out to a person who is suffering, and not merely treating a sick body. This is why a commitment with the features of a vocation is asked of health-care workers. Experience teaches you that the sick person is asking for more than a mere cure of the organic pathologies affect him. He expects support from the doctor in order to face the disquieting mystery of suffering and death. To give the sick and their relatives reasons for hope in the face of the pressing questions that beset them: this is your mission. The Church is close to you and shares this impassioned service to life with you.

Christians are called to evangelize the world of health care

5. In a globalized society like today's, with increased technical potential but also new difficulties, you have paid special attention during your congress to the new diseases of the 21st century. Nor have you failed to look at the conditions of health care in certain regions of the world which lack policies of support for primary care. In this regard, I have often had occasion to call on the responsibility of governments and international organizations. Unfortunately, despite praiseworthy efforts, in recent decades the inequalities among peoples have seriously worsened. I appeal once again to those responsible for the destiny of nations to do all they can to encourage suitable conditions for solving such tragic situations of injustice and marginalization.

6. Despite the shadows that still fall on many countries, Christians look with hope at the vast and varied world of health care. They know they are called to evangelize it with the vigour of their daily witness, in the certainty that the Spirit continually renews the face of the earth, and that with his gifts he constantly spurs people of good will to open themselves to the call of love. Perhaps it will be necessary to take new paths to find suitable answers to the expectations of so many suffering people. I am confident that those who sincerely seek the total wellbeing of the person will not lack the necessary light from on high to undertake appropriate initiatives in this regard.

Dear brothers and sisters, may Our Lady, Seat of Wisdom and Health of the Sick, invoked in Tradition as the New Eve, guide your way. You are committed to one of the noblest causes: the defence of life and the promotion of health. May the Lord sustain you in your quest and always grant you new zeal in your most noble service to your fellow men and women.

With this hope, which becomes a prayer, I impart my Blessing to you all.

Health Care and Society

JAVIER LOZANO BARRAGÁN

Introduction

The Pontifical Council for Health Pastoral Care has already organised fourteen international conferences on subjects of great contemporary relevance. Now, with the help of God, we are about to begin this fifteenth international conference on 'health care and society', that is to say on the subject of pastoral care in health in the present-day context of the society in which we are living.

As an event within the framework of the solemn reality of the Great Jubilee, in this conference we will address ourselves to the inculturalisation of the Gospel within the contemporary context of health care. In line with the basic process of inculturalisation, we are face to face with two poles – the Gospel and health. From these two poles arises the need for the Gospel to enter the very heart of health and health care and to root itself in it, so that the world of health and health care becomes transformed by the Gospel. This pre-supposes a new evangelisation of the world of health, that is to say the transformation of health care into Christian health care. This inculturalisation of health and health care constitutes authentic pastoral care in health. We must enter the fundamental values of the world of health and health care in order to transform them and make them every time more in accord with the Gospel.

Our Ministry, which is rightly the Ministry of Health Pastoral Care, is interested in a direct and immediate way in this subject, which specifies its character and provides it with its legitimacy. How can we inculturise the Gospel in the world of health and health care?

During this conference without doubt suitable answers will be provided which respond to the contemporary globalisation of health and health care, to the problems of biogenetics, to the problems of the new situation of Catholic hospitals, to their economic problems, to the problems of committees of bioethics within hospitals, to the new management of many hospitals which belong or belonged to religious orders and congregations, and to co-operation between hospitals which are dependent on the public health system or those which are dependent on private non-Catholic systems.

It is our hope and wish that this international conference of ours will illuminate us deeply on the meaning of the world of health and health care in the light of the Word of God, and that it directs and guides us in relation to the complicated moral problems which contemporary situations raise for us. We also hope and wish that to the light provided to us by the Catholic Church we will add the clarification which will derive from dialogue with the other religions, and that we will reach practical conclusions in relation to the policies which should be followed in the various fields of health care activity.

With these perspectives, our conference will open with a highly instructive paper given by His Eminence Cardinal Darío Castrillón Hoyos, Prefect of the Congregation for the Clergy, which will dwell upon contemporary medicine in the light of the Word of God and then enter into the realities of the world of health and health care by touching upon the new frontiers of medical technology, the new places of health care, the new workers of health, the new kinds of patients, and emergency illnesses. After this, continuing the illumination of reality which we will receive from this paper, we will refer to the history of medicine, especially during epochs of cultural change, so as to then deal directly with the subjects of theology and medicine, the contemporary questions of moral theology, and the light that we can encounter through inter-religious dialogue with Judaism, Islam, Hinduism, and Buddhism.

Our conference will reach its practical conclusions by laying stress upon pastoral care in contemporary medicine, the situation of hospitals during our time, charity and modern technology, new frontiers, and the training of health care workers, voluntary workers, and chaplains.

The quality of the speakers and chairmen is widely recognised within the world context of health and health care. I would like to thank each one of them for the kindness they displayed in accepting our invitation and for enlightening us with their learning and expertise in the various fields which are touched upon by our conference.

I would also like to extend a very special greeting to each and every participant. You will take part in the various dialogues which will take place and you will expound to us your different points of view. As you can see from the programme, after a series of subjects which will be addressed by specialists a debate will take place in which everyone will be able to participate. We hope and wish that the dialogues will be rich and interesting so that the matters dealt with in the conference will be further clarified.

You are all welcome. We await your fruitful co-operation.

It is an honour now for me to hand over to His Eminence Cardinal Fiorenzo Angelini, the Emeritus President of this Pontifical Council, who will be so kind as to extend his greetings to those who are present.

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

FIORENZO ANGELINI

Medicine and Society

For those people who work in the field of health care and health, to speak about medicine and society means above all else to speak about medicine and civilisation, about medicine and morality.

The level of maturity of a society depends on the civilisation which inspires its laws and structures and guarantees that practice is consistent with them.

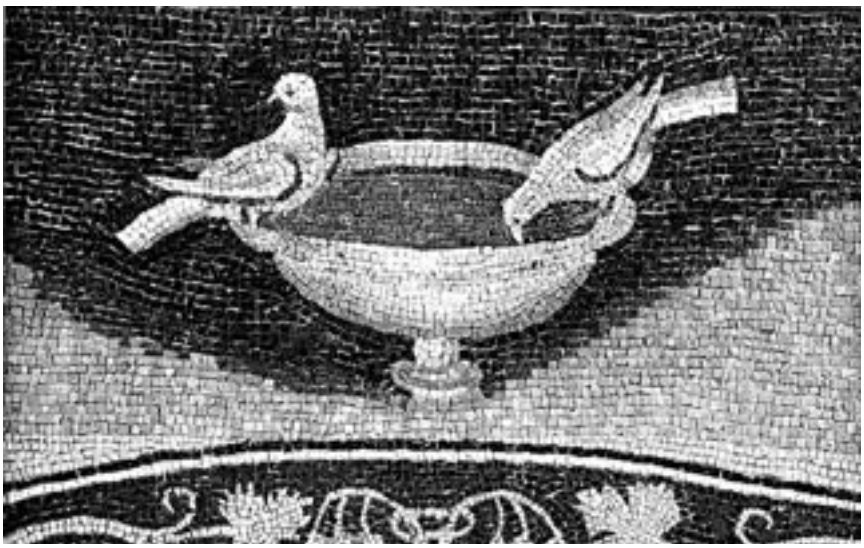
The Hippocratic oath itself has as its premise and assumption a moral vision of human life – a vision of service to life, to the sacredness and inviolability of life, and to the quality of life.

This is not a vision of life which is exclusive to Christians, or which is under the banner or in the name of a religious faith. As the Holy Father John Paul II has stressed with great force and emphasis: 'No single person or group has a monopoly on the defence and promotion of life. These are everyone's task and responsibility'.[1] Although it is true, in fact, that 'faith provides special light and strength' in relation to the question of life, 'in no way is that value a concern only of believers. The value at stake is one which every human being can grasp by the light of reason; thus it necessarily concerns everyone'.[2]

If the defence and the promotion of life are the field of civilisation in which society calls upon medicine to operate, it follows from this that there is a very close connection between civilisation and the ethical and moral vision of the human person, and thus between medicine and society.

Indeed, we are called upon to adopt a moral approach – towards the defence of unborn life and against abortion; towards responsible motherhood and fatherhood and against selfish population control; towards the medicine of transplants and against genetic biology which threatens the roots of the individuality of the human person; towards the safeguarding of the right to die in peace and against euthanasia; towards the humanisation of medicine and against every bureaucratic and depersonalising form of medicine; towards the right of everyone without any exceptions to health, and this without any form of discrimination.

The choices of society in this field are choices between civilisation and anti-civilisation.



Just as the advance of science and technology is the fruit of constant study and requires increasingly intense training, so also is it the forward path of a society which wants to be of sufficient stature in relation to the instruments which science places at its disposal.

We must objectively recognise that even in the case of the most well trained and aware health care workers the wish to be fully up to date in relation to knowledge of the increasingly advanced technical opportunities which are offered by medicine tends to place in the shade a corresponding ethical and moral grounding and training.

More than was the case in the past, human reason must today become aware that it must not remain a prisoner of advances which, once they have been achieved, bring to the fore frightening possibilities which only a broader vision – of a spiritual and transcendent character – can control in the right way.[3]

It is specifically the rational analysis of the imbalance, the state of ill-being, and the illness which afflict modern man, the creator and at the same time the victim of technological progress, which brings out a new idea of health – an idea which is more complete and global.

This postulates an anthropological diagnosis which reaches the *spiritual patient,* which discovers, that is to say, the roots of the malady, in addition to the mechanisms and the spectrum of his physical reality and his psyche.

Medicine in its expressions in prevention, diagnosis, therapy and rehabilitation, works with rigour and methods that are not arbitrary in character.

Society must be aware of this truth.

There must, therefore, be a medi-

cine of the spirit, almost a form of spiritual ascetics which helps to prevent the spirit from falling into the shadows of modern anxiety, or which helps to liberate it from those shadows if it has already fallen prey to them.

In other words, in order to solve the dilemma, man, whether creator or victim of technical progress, must engage in a non-scientific choice, a choice which is ethical and spiritual, that is to say a choice in favour of civilisation. A rational choice, not an emotional choice.

All this certainly does not involve an ambiguity in the meaning of the term and concept of 'health' but means, rather, its necessary completion. This is because a man cannot become healed if the therapy does not reach the psyche and does not heal that unitary nucleus which can only be expressed adequately with the term *spirit.*

The health of the spirit is not only a pre-condition of mental-physical health but an authentic liberation of resources. It is thus an instrument for the real co-ordination of the progress of science itself, where everything is at the service of a worthy quality of life.

Every analysis of the socialisation of medicine and the relationship between its practice and social structures must act on those premises, abandoning which medicine, in all its expressions, is not only unable to give of its best but is also exposed to extremely dangerous forms of being used and exploited.

Today there is much talk about health policies directed towards upholding and ensuring the universal human right to health and to quality of life.

The lines along which every authentic and effective health care policy can and must run are those of the promotion and defence of life welcomed as a gift of God. A society which sees the practice of medicine in these terms is called upon to have a very positive appreciation of voluntary work, something which is seen not as a stand-in for the inadequacy of structures and staff but as a stimulus which enriches both.

The Christian response to this reality is to be found in the Gospels where it is expressed not in philosophical or theological terms but through an image which is even more exhaustive and complete in character, namely the image of the Good Samaritan.

The Good Samaritan, although placed in a historical period which had no knowledge of the modern advances of medical science, is a figure achieved by a mature civilisation because he bends down 'with love' over the wounded man, who asks for the retrieval of his life.

Expressing himself as love, the Good Samaritan, that is to say Christ himself, fuses the human with the divine in the synthesis of love. 'Man cannot live without love. He remains for himself an incomprehensible being, his life is without meaning, if love is not revealed to him, if he does not encounter love, if he does not experience it and make it his own, if he does not participate in it strongly'.[4]

'Institutions are very important and indispensable. However, no institution can alone take the place of the human heart when one is dealing with encountering the suffering of another person'.[5]

Contemporary society, and this is especially the case in advanced countries, suffers from an insufficient interaction between professionalism and sensitivity, between profession and vocation.

Only from their mutual encounter can there mature that civilisation of service which is clearly the safest parameter of a form of medicine which is of sufficient stature to match the advances achieved by science and technology.

His Eminence Cardinal
FIORENZO ANGELINI,
President Emeritus of the Pontifical Council for Health Pastoral Care, the Holy See.

Notes

[1] JOHN PAUL II, encyclical letter, *Evangelium Vitae* (25 March 1995), n. 91.

[2] Ibid., n. 101.

[3] C.J. PINTO DE OLIVEIRA, *La Crisis della Scelta Morale nella SocietB Tecnica* (Turin, 1978), pp. 65-66: 'The problems raised or made more acute by technological civilisation and, at the same time, the questions of the men and women of our time converge to remind us of the dangers of the domination of a one-dimensional rationality. The scientific approach, the multiplicity of the branches and times of its research, the limits to knowledge and its communication, are all factors which throw new light on the possibility and the universal and coherent use of reason. Human reason presents itself today, with greater force than was once the case, as a multi-dimensional capacity for knowledge and reveals its deep coherence only at the price of reflection which is as necessary as it is difficult. From a directly ethical point of view... reason is endowed with multiple and correlative intentionality, as a capacity to decipher the world and man as an individual subject, as inter-subjective communication, as vocation to development, that is to say, as rising above, as transcendence'.

[4] JOHN PAUL II, encyclical letter *Redemptor Hominis,* n. 10.

[5] JOHN PAUL II, encyclical letter *Salvifici Doloris,* n. 29.

DARÍO CASTRILLÓN HOYOS

Medicine Today in the Light of the Word of God

1. Introduction

In this Jubilee year the whole of the Church is celebrating the two thousand years which have passed since the Incarnation of the Word of God. This is a very meaningful historical moment, when our minds and our hearts are engaged in trying to penetrate the mystery of the Word made flesh, a truth of faith which, however, is something which, with our poor human intelligence, seems to us something which it is difficult to accept. Goethe, the multi-talented German man of letters, recognised that 'the supreme happiness of the rational being consists in exploring the whole of that which can be investigated and silently venerating that which cannot be investigated'. In the mystery of the Incarnation of Christ there come together the two elements of that which can be investigated and that which cannot be investigated – science and mystery.

2. Medicine in the Light of the Mystery of the Incarnation

We have to engage in violence against our minds in order to discover in the mystery of the development of a human embryo the Word of God which was made man. Today, two thousand years after the birth of Christ, we find ourselves in the condition of being able to describe all the stages of the process of growth and development of an embryo, but we go on turning to faith to understand that the God who gives life, the Creator, the Lord of all things, the Second Person of the Most Holy Trinity, the Word which has the same nature as the Father,[1] is present at all of the stages of the development and growth of the embryo. This and only this is the profound meaning of the phrase to be found in the Gospels: 'the Word was made flesh and came to live amongst us'.[2]

Two thousand years ago an ovule was fertilised in a prodigious way thanks to the supernatural action of God. What a happy phrase is the following: 'The Holy Spirit will come upon thee, and the power of the most High will overshadow thee. Thus this holy offspring of yours shall be known for the Son of God'![3] Thus it was that from this marvellous union there sprung a zygote which had its own chromosomal endowment. But in this zygote was the Word of God. In him was placed the salvation of men.

About seven days after this event there took place the nidation of the blastocyte in the mucous of the endometrium and God was thus reduced to being a human embryo. However, this embryo was the Son of God and in him was placed the salvation of men.

This alecithal egg developed slowly and as the segmentation of the egg gradually developed, its differentiations and the growth of the first forms of tissue, organs and embryonic apparatus began to appear. This new alecithal entity was the Son of God, the Second Person of the Trinity, and in him was placed the salvation of men, of all men, of each and every human being.[4]

In the first month of pregnancy, when the foetus already measured from 0.8 to 1.5 centimetres in size, the heart of God began to beat with the strength of the heart of Mary and to use the umbilical cord to gain nourishment from his mother, the Immaculate Virgin. The Word of God totally depended upon a human being, yet at the same time he possessed total genetic autonomy. However, nine months had to pass while the Word of God was in amniotic liquid, in the placenta which protected him from the cold and the heat and provided him with nourishment and oxygen, before he was born at Bethlehem and saw his first human face, certainly that of his Mother, with eyes which had recently opened.

Thus it was that Jesus Christ became the first born of every creature,[5] the new Adam of the new creation.

The Son of God redeemed creation with the most marvellous of works – the human being. The redemption of man, indeed, began with the embryonic state. For this reason, the Catholic medical doctor must have the following approach in order to understand his own mission – the Son of God was a zygote, an embryo, and a foetus, before playing in the streets of Nazareth, before preaching on the shores of the Sea of Galilee, or before dying crucified in the environs of Jerusalem. The Son of God completely, and without any reservation at all, took on the vocation of being a man.

3. Medicine and Creation

During the twentieth century science has achieved great advances. It has been able to identify almost the whole of the human genetic code, it has broken the mystery of the origins of life, and has managed to penetrate deeply into the process of conception. Despite this fact, it still has some things to do: the study of man as man, in all his profundity. Not man as biology, nor man as psychology, but the human essence. Man in his profundity: his ideals, his must unconfessable fears, his motivations, his questions and answers, his world of affections, his capacity to overcome things, and his disappointments, love and pain. One can say that science is outside the doors of the human spirit in the same way as it might be face to face with a foreign field which cannot be penetrated. There is, however, almost a be-

lief which is held by the scientist who draws near with honesty to the study of man, and that belief is that not everything ends with genetics, with psychology, or with psychiatry. There is a spirit which goes beyond biology, physics, chemistry, and mathematics, a spirit which attracts our attention, the same spirit, indeed, which makes every act of research possible.

Man is a psychosomatic unity of *soma* and *psyche*. In the embryonic state there is a mystery and a special dignity – that of the spiritual being. And this is something which medicine cannot forget about. Today, when we see human beings used as laboratory matter or thrown away in the form of frozen embryos; when we see terminally-ill people isolated in wards equipped with the latest discoveries of technology but without the affection and the nearness of their loved ones, a question comes into our minds: is it not the case that science is forgetting about the deepest part of man and in fact merely disdaining what escapes its field of study?

The mystery of man us the mystery of a being who is a citizen belonging to two worlds. An animal? Yes! A biological being? Yes! But he is also endowed with an ungraspable and unfathomable spirit. A Son of God, a Brother of Jesus Christ. A being who is social by his nature and needs the human presence of his own kind in order not to feel that he is a stranger in his own environment. An imperfect creature who experiences pain, but at the same time a creature redeemed by Christ. The intensive treatment wards where so many patients struggle between life and death have been taken over by technology, which is welcome, but they have left out the comforting presence of families or the zealous spiritual support of a priest. Technology seems to have triumphed over the spiritual aspects of man, when in fact what is needed is a complementary relationship between the two. Technology? Yes! But without forgetting about this intimate dimension of the human spirit which continues to slip out of the hands of medical science. 'You should know that the human being infinitely rises above the human being'.[6] How tragic it must be for a paediatrician to see the life of a child slip out of his hands!

We often have the impression that the human person is not perceived in the sick person and that only a biological individual is seen. This is something which is explicable given the technological character of medical care and treatment but it is something which does not correspond to the human nature of the sick person, a person who suffers, because 'the sick person must feel that his illness is understood as an event of life, and understand recovery as an act which helps life, not as the mere repairing of the defect of a machine. But in turn, this is impossible without a specific ethical approach, that is to say without profound respect for life and without matching sympathy for life. To lay stress on all this is not sentimentalism, but, on the contrary, belongs to the essence of the health care approach'.[7]

Man must exercise his lordship over the creation which has God has entrusted to him,[8] but his lordship over the creation begins with lordship over himself. The medical doctor is certainly someone who lives out this struggle with greater clarity, a struggle, that is to say, to dominate the creation in the realm of life and bring it to the service of man. With research or treatment he struggles to grasp in his innermost being the behaviour of nature and to direct it towards the good of the human being, towards the maintenance of life. But he should not forget that he must do this beginning with himself, with the molecules of his own being, with his own worries and cares, with his own fears and his own wishes to love and to be loved, with his own life, and above all else with his own spirit. The medical doctor sees in himself the man he cares for and treats, he experiences within himself what his patients experience, and it is from here that there is born a compassion and a very special human nearness to the human being who suffers, with the person who turns to him.

4. Medicine in the Light of the Mystery of Pain

This observation brings us to another mystery in which medicine finds itself at the end of this century – the mystery of pain. The man of the twentieth century is averse to pain. He wants to uproot it at any cost from his life, but he has also begun to realise that this is impossible. Hedonism has led us to search for perfect health, for eternal youth, and for the fullness of strength prolonged for as much time as possible. And in this project, the appearance of illness, of pain, and of desolation becomes something which is bitter, something which is unacceptable. Where is this search for perfection when the human being finds himself face to face with incurable illnesses such as AIDS? Where is technology when in our hands there is not to be found that pill which provides an immediate remedy? Where is science to be placed before the inevitable reality of death? Why has human genius not been able to distance the weight of the cross from the life of man?

Human life is full of crosses which we cannot destroy, a thousand crosses which touch us from nearby or from a distance. There are many forms of human pain which do not have their medical remedy. In the face of this problem, what approach should we adopt? That of the masochist who enjoys pain? No! We should adopt that of the human being redeemed by Christ who sees in pain a path of love, the approach of Christ in front of the cross. 'Pain and illness are a part of the mystery of man on earth. It is certainly the case that it is right to fight against illness because health is a gift of God. But it is also important to know how to read the design of God when suffering knocks at our door'.[9]

Jesus was not a masochist, but loved the pain which he threw off.[10] Here is the basis of the acceptance of pain. Here we encounter his teaching: 'if any man has a mind to come my way, let him renounce self, and take up his cross, and follow me'.[11] To follow Christ we must renounce ourselves and take up that cross. 'Christians must imitate the sufferings of Christ, and not try to achieve pleasure. One comforts a faint-hearted person when one says to him: resist the temptations of this century, the Lord will free you from everything if your heart does not draw away from him. Because precisely to strengthen your heart he came to suffer, he came to die, to be spat on in the face and to be crowned with thorns, to listen to insults, and to be, finally, crucified.

Everything that he did, he did for you, while you were not able to do anything for him, only things for yourself'.[12]

'For two thousand years, from the day of the Passion, the Cross has shone forth as the highest expression of the love of God for us. The person who knows how to receive this, in his life experiences how pain, illuminated by faith, becomes a source

of hope and salvation'.[13] The sign of the disciples of Christ is this generous acceptance of suffering, something which is absurd for today's man and for the man of all times, something which is foolishness,[14] perhaps because, as St. Paul said, 'Mere man with his natural gifts cannot take in the thought of God's Spirit; they seem mere folly to him, and he cannot grasp them, because they demand a scrutiny which is spiritual'.[15] But let us return to the spirit of man, something which goes beyond the progress of science.

St. Basil observed that 'often, despite themselves, illnesses are punishments for sinners, sent for our conversion. The Lord, it is written, punishes those he loves'.[16] And later on he goes on to add: 'It is for this reason that in your midst there are many sick and infirm people, and a good number who have died. If, however, we carefully examine ourselves, we are not judged. When, however, we are judged by the Lord we are rebuked for not having been condemned together with this world'.[17] For this reason, if we find ourselves in such conditions, after recognising our faults and abandoning the use of medicine we must bear this suffering in silence, in conformity with he who proclaimed: "I will bear the disdain of the Lord because I have sinned against Him";[18] and we must also correct ourselves to the point of eating the fruits of repentence, once again remembering the Lord who declared: "Behold thou hast recovered thy strength, do not sin any more, for fear that worse shall befall thee".[19, 20] In this instance illness is also the path which leads to conversion.

His Holiness John Paul II is a teaching master of the meaning of pain, and he has taught us to find the meaning of this mystery which torments man. He is a Pope who is very near to human suffering. He easily identifies with the pain of sick people, shares the misfortune of others, is concerned with all those men who seem to be afflicted in a physical or spiritual way. I remember, for example, a moment when, during an apostolic visit to Brazil, a street child broke through the security barrier and drew near to the Holy Father to ask him for alms. The Pope took off his ring and gave it to the child. Through this gesture we discover the heart of a compassionate man who is near to the pain of other people.

Seeing John Paul II one can use that phrase of St. Paul: 'in this mortal frame of mine I help to pay off the debt which the afflictions of Christ leave to be still paid, for the sake of his body, the Church'.[21] It is precisely with this sentence that the Pope begins his apostolic letter *Salvifici Doloris*. It captures his deep reflections on human suffering united to the cross of Jesus Christ.

Suffering, in the profound thought of Pope John Paul II, is 'really supernatural and at the same time human because it is rooted in the divine mystery of the redemption of the world, and it is, equally, profoundly human because in it man finds himself, his own humanity, his own dignity, his own mission'.[22] Pain is the profound moment when the human being finds himself with himself. Those who have worked in the field of pastoral care in health know the very dramatic truth to be found behind this statement. Pain is a moment when man is presented face to face with himself, without reserve, without attenuations, and without falsehood.

The Pope also said that pain is also a test,[23] a test that gives proof of love, which makes the love of God in the world present. Human suffering is often an expression of love. Pain felt for the loved being who is no longer near to us is a new way to express our love for him. The same love which previously was borne witness to in caresses or embraces now becomes pain provoked by an absence.

Love and pain constitute a tandem which is closely bound up with our Christian faith. Love and pain are realities which exist in a way which is closely bound up with the Christian images which fill our churches, our times, and the deepest part of the Christian heart. Love which has become pain and pain which is always alive in love, following the example of Christ. Pain without love generates only affliction and desperation, rebellion and dejection. Love without pain is fragile, superficial, incomplete, and changeable. The culture in which we are immersed promises happiness in this life and presents it as being something which is near to hand, something which it is easy to build up without the expenditure of further effort, but we human beings know by experience that happiness in love requires sacrificial personal self-giving. Pain can be a path towards love and it is authentic and complete love only if it is arrived at through the pain of personal self-denial in favour of another person.

Pain is also a path of hope thanks to the Resurrection of Jesus Christ. It is what is reflected in the face of the Pietà by Michelangelo – here we encounter pain provoked by the dead Son, and at the same time a serene hope that everything does not finish here. There is something which comes after. Pain is not the purpose of human existence but a stage, an Easter towards salvation. Pain is salvific in nature.

Pain lived out with a sense of eternity is a sign of hope for the world of today. Just as the 'Good Thief' of the Gospels is moved and becomes converted when he sees the suffering of Jesus Christ,[24] so the Christian response to human suffering is certainly one of the greatest signs working for the credibility of the Gospel. To accept pain and to

serve those people who suffer are the great messages of contemporary Christianity for a world which is not inspired by solidarity and which often despises the person who suffers. Pain lived out in sacrifice for others is the sign of the disciple of Christ: 'to celebrate the Eucharist by eating his flesh and drinking his blood means to accept the logic of the cross and of service. It means to be ready to sacrifice oneself for other people, as he did'.[25] Pope John Paul II sees his suffering as service to the Church. To suffer is to serve, he says in the apostolic letter *Salvifici Doloris*.[26] It is the completion of Jesus Christ in favour of the Church. The Pope sees his suffering as a way of living his own identity as the 'servant of the servants of God'. A man whose vocation is not that of living for himself but that of living for other people.

5. Medicine in the Light of the Mystery of Love

This last thought introduces us to the core of the medical profession, today and always – love for man. Medicine is not a theoretical science which proclaims simple laws and theories following the empirical-theoretical method. It is something more, it is science placed at the service of man in relation to what is most valuable in him, life, because life is the basis of other gifts. Medicine is a science which becomes service and 'service' is the best word to define the approach of Christ adopted towards man during his life amongst us – to serve and give his life to redeem many.[27] The medical doctor, the health care worker, place their own lives at the service of others in sacrificing themselves. How many forms of care and treatment for the sick person, how many hours of dedication, how many deprivations, and how many sacrifices made out of love in the attention paid to neighbours who suffer!

Medicine is love which provides a remedy for pain. It is compassion, loving drawing near to the sick person, who is seen as a neighbour who suffers. It is a technical reality which studies how to provide a remedy to pain. It is a science that draws near to the human being, a sinner, but a very much loved son of God. Medicine is a discipline which discovers in man his highest dignity and turns to God as the ultimate reference of this dignity in order to go beyond the limits of its knowledge: 'What or who was the motive lying behind why you made man with such dignity? Certainly, nothing that was not the inextinguishable love with which you contemplated your creature in yourself and you allowed yourself to draw near out of love for him. You created him out of love, out of love you gave him a being able to experience your eternal Goodness'.[28] The sick person is not only an object of study of medicine, but a neighbour who must be served with the generous dedication of one's own life and with the admiration of one who knows that he is before a being who has his own dignity and his own mystery: the dignity of the son of God and the mystery of the triune dwelling place.

In this sense, medical science is a gift of God which allows man to redeem one of the most visible effects which sin has left in his nature – illness. St. Basil explained this with language which it seems to me was very eloquent in its simplicity: 'When our body is sick, reduced by infirmity or disturbances of various kinds, for external or internal causes, because of food eaten, because of its excess or its lack, God, the moderator of our existence, has granted to us the gift of medical science, thanks to which the superfluous is cut down to size and what is found in reduced measure is increased. Indeed, if we were in heaven we would not in any way need to know or practice agriculture, and at the same time if we were immune to illness, as was the case before the Fall, we would not need the help of medicine to heal us. Despite this fact, after being expelled from that place and heard declared: "with the sweat of your brow you will eat bread",[29] after making a great deal of effort to cultivate the land, we invented the art of agriculture to mitigate the harmful effects of divine malediction, while God himself fostered in us intelligence and knowledge of that art. Then, in the same way, given that we were ordered to return to that same clay from which we were formed and given that we are bound to our suffering flesh, destined for death because of sin and subject because of it to illness, we have also been offered the help of medicine so that in certain contexts and to a certain extent the sick can be healed.

Thus it is no accident that in the earth plants have been created which are destined for the treatment of every illness, More than this, they find their origins in the will of God, so that they could reduce our maladies. Precisely for this reason, that natural curative effectiveness found in roots, in flowers, in leaves, in fruits, and in juices, as in everything that minerals or the sea have which is therapeutic, is not different from similar elements discovered in food or drinks... Christians must seek to use medicine when this is necessary so that they do not attribute to it all the causes of good or bad health, and use the means that medicine offers us to render glory to God... In no case, and certainly not because some people use medicine in a stupid way, should we renounce its usefulness. In reality, it is not because certain intemperate persons, in practicing the art of the kitchen or the bakery or clothes, engage in abuse in their approach to voluptuous things, going beyond the limits of necessity, that all arts should be rejected by ourselves... The benefits of good health are given to us, both by wine mixed with vinegar,[30] as in the case of he who found himself with the thieves, and by figs, as in the case of Ezekiel'.[31, 32]

The medical doctor and the health care worker work together in the fight against the effects of sin, the ultimate cause of illness. Medical doctors know what this redemption of our bodies referred to by St. Paul means.[33] Their struggle against biological malady is a sign of the love of God which continues to reconquer the creation through man. The health care worker uses the gifts of man to serve his brothers and sisters. If man, each and every man, can co-operate with man in his salvific action, then it also the case that medicine struggles against the disorder that sin left in the world. Medical doctors and health care workers: you should be signs of this love of God for man. You should be men and women who place their own lives at the service of man, fighting against evil and triumphing over it with love. You should be instruments of the mercy of God, you should be the presence of the re-

demptive love of Christ who welcomes and cures. You should not allow your vocation to become lost in a cold and distant pragmatism which does not go beyond technology and natural laws. The medical doctor, the health care worker, can be a sign of the love of God amongst men, people who place their own heart amidst human misery. This is compassion, the weakness of God, and our strength.

6. Conclusion

In two thousand years, the human being has learnt many things. He has a established a deeper relationship with the reality which surrounds him. One could say that today he knows the created world with greater exactness, from the macrocosm to the microcosm. He has discovered the laws which maintain life and the causes of illness, laws which followed on from ancient conjectures which had no scientific basis. In recent centuries he has made gigantic steps forward in the penetration and understanding of the processes of human life. Precisely because of this, now that we know man better, now that medicine has entered more into the secret of the transmission of life, now that we advance in medical technology and science, we also advance and go forward with greater respect for this wonderful gift of God. All our scientific efforts would be worth nothing if they were not translated into a more complete service towards each and every human being with respect for his integrity and in a compassionate view of the spiritual richness which is manifested to us in his works, and they would also be worth nothing if this fact escaped our instruments of study. We respect man, we love man, we protect his mystery, and we protect his spirituality.

I would like to finish by referring to the Most Holy Mary, the Mother who gave her generous 'yes' to the Incarnation of the Word,[34] and who accompanied the wounded Christ in his trial,[35] when he was covered with wounds, ill-treated, and had the thirst of the dying.[36] The reality of this ordeal is the reality which we live out in many first aid wards. Mary accompanied the bleeding and bruised wounded Jesus, who looked at his Mother, from whom he received comfort. For this reason, we Christians, when we feel oppressed by pain, have learnt from Christ to find refuge in the arms of Mary, like a baby who finds himself in front of a danger and runs to the arms of his own mother and gives way to crying. May Mary, the consoler of the afflicted, the help of the infirm, accompany us in this congress and help us to investigate everything that can be investigated and at the same time silently and humbly venerate what cannot be investigated!

H.Em. Cardinal DARÍO CASTRILLÓN HOYOS,
Prefect of the Congregration for the Clergy the Holy See.

Notes

[1] Cf. the Niceno-Constantinopolitan creed.
[2] Cf. John 1:14.
[3] Luke 1:35.
[4] Cf. Congregation for the Doctrine of the Faith, the declaration *Dominus Iesus* 12-15, 6 August 2000.
[5] Cf. Colossians, 1:15-16.
[6] B.PASCAL, 'Apprenez que l'Homme Passe Infiniment l'Homme', in *PensJes*.
[7] R. GUARDINI, 'Etica, Lecciones en la Universidad de Munich', c. 11,2, BAC, Madrid, 1999, p. 715.
[8] Cf. Genesis, 1:28-30; 9:7.
[9] JOHN PAUL II, 'Omelia in Occasione del Giubileo dei Malati e degli Operatori dei Malati e degli Operatori Sanitari' (Homily on the Occasion of the Jubilee of the Sick and Health Care Workers'), Rome, 11 February 2000.
[10] Cf. Matthew 26:39.
[11] Cf. Matthew 16:24; Luke 9:23.
[12] ST. AUGUSTINE, *Sermons on Pastors*, Sermon 46:10-11.
[13] JOHN PAUL II, 'Omelia in Occasione del Giubileo dei Malati e degli Operatori Sanitari' ('Homily on the Occasion...'), Rome, 11 February 2000.
[14] 'To those who court their own ruin, the message of the cross is but folly; to us, who are on the way to salvation, it is the evidence of God's power. So we read in scripture, I will confound the wisdom of wise men, disappoint the calculations of the prudent. What has become of the wise men, the scribes, the philosophers of this age we live in? Must we not say that God has turned our worldly wisdom to folly? When God shewed us his wisdom, the world, with all its wisdom, could not find its way to God; and now God would use a foolish thing, our preaching, to save those who will believe in it. Here are the Jews asking for signs and wonders, here are the Greeks intent on their philosophy; but what we preach is Christ crucified; to the Jews, a discouragement, to the Gentiles, mere folly; but to us who have been called, Jew and Gentile alike, Christ the power of God, Christ the wisdom of God. So much wiser than men is God's foolishness; so much stronger than men is God's weakness'. (I Corinthians, 1:18-25).
[15] I Corinthians, 2:14.
[16] Proverbs, 3:12.
[17] I Corinthians, 11:30-32.
[18] Michea, 7:9.
[19] John 5:14.
[20] BASIL THE GREAT, *Regole Lunghe*, 55, 1-5.
[21] Colossians 1:24.
[22] JOHN PAUL II, Apostolic Letter *Salvifici Doloris*, 31, 11 February 1984.
[23] Cf. *Salvifici Doloris*, 23.
[24] 'And one of the two thieves who hung there fell to blaspheming against him; Save thyself, he said, and us too, if thou are the Christ. But the other rebuked him; What, he said, hast thou no fear of God, when thou are art undergoing the same sentence? And we justly enough; we receive no more than the due reward of our deeds; but this man has done nothing amiss. Then he said to Jesus, Lord, remember me when thou comest into thy kingdom. And Jesus said to him, I promise thee, this day thou shalt be with me in paradise' (Lk 23:39-43).
[25] JOHN PAUL II, 'Omelia durante la Chiusura della XV Giornata Mondiale della Gioventj' ('Homily during the Closing of the XV World Day of Youth', Torvegata, Rome, 20 August 2000, 5.
[26] Cf. *Salvifici Doloris*, 27.
[27] Cf. Matthew 20:28; Mark 10:45.
[28] Cf. ST. CATHERINE OF SIENA, *Il Dialogo della Divina Provvidenza*, 13, ed. G. Cavallini (Rome, 1995), p. 43.
[29] Genesis, 3:19.
[30] Cf. Luke, 10:30-34.
[31] Cf. 2 Kings 20:7.
[32] Cf. BASIL THE GREAT, *Regole Lunghe*, 55, 1-5.
[33] 'Created nature has been condemned to frustration; not for some deliberate fault of its own, but for the sake of him who so condemned it, with a hope to look forward to; namely, that nature in its turn will be set free from the tyranny of corruption, to share in the glorious freedom of God's sons. The whole of nature, as we know, groans in a common travail all the while. And not only do we see that, but we ourselves do the same; we ourselves, although we have already begun to reap our spiritual harvest, groan in our hearts, waiting for that adoption which is the ransoming of our bodies' (Letter of St. Paul to the Romans, 8:20-23).
[34] Cf. Luke 1:38.
[35] Cf. John 19:25.
[36] Cf. John 19:28.

Section I
A Conflicting Reality

ALFONS HOFSTETTER

I: The Limits of Technology

The topic of my lecture is *"The limits of technology* as illustrated by an example from medicine – the development of a vaccine against kidney-cell and prostate carcinoma".

Technology without limits

New scientific knowledge and the feasibility of technical solutions suggest that today technology has no limits, and that it can enable human beings to penetrate the endless depths of space and to analyze the microcosmos down to its molecular structures. This has led not only to enormous changes in our scientific view of the world, but it also of course affects the humanities, and even religion and spirituality. Are there not sects who claim to have direct contact with the Godly on the basis of new scientific knowledge?

With its discoveries, the last century made quantum leaps in technological progress. Today, we have to ask ourselves whether this progress is only the beginning of unlimited development or whether there are limits to these advances. Space research, molecular biology and the quite unlimited possibilities of the communication media cause many people today to believe that there will no longer be any progress without technology. Are the humanities therefore subordinate to natural sciences? Is it only technical advances which enable social development, cultural and civilizational progress? If so, this would ultimately mean that when technology has reached its limits, all human activities and advances will come to a halt. That cannot be.

Limits of technology

The limits of technology are contingent on the laws of nature and the laws of civilization, ethics and morality. If we consider technology in the individual scientific disciplines, it is evident that there are plenty of constraints on the implementation of scientific ideas. However, it does not mean that these boundaries will be swept away tomorrow or the day after and that the ostensible boundlessness will reappear. Experience in past decades has confirmed this time and again.

Ambivalence of genetic engineering

May I refer in this connection to the developments in genetic engineering, where gene-manipulated forms of agricultural plants suddenly develop properties of pest resistance as well as resistance to environmental and climatic stress, so that there is justified hope that the problem of feeding the world's population will be resolved. Further examples are the development of certain animal breeds and the cloning of animal species as well as the experiments to create spare organ stores by cloning stem cells from human embryos. If the latter boundary should be surmounted, the barrier to cloning human beings is no longer very great, i.e. this would open the way to contravening established moral conventions.

Genetic engineering is not to be equated with transcending moral boundaries. This is shown *inter alia* by our endeavors in the field of carcinoma research. This research is absolutely necessary today because cancer therapy in its present form appears to have reached definite limits in its present form of *surgical operations, chemotherapy and radiotherapy*, or at least has not advanced further in recent decades.

Gene therapy

The concept of gene therapy was originally developed to treat diseases based on genetic defects. The intention was to correct the defective gene sequences by introducing copies of healthy genes. This definition of gene therapy was very quickly extended so that the term *gene therapy* now comprises both *therapy of genes* and *therapy with genes*. Therapy with genes is based on the specific introduction of new genes into the afflicted cell in order to achieve therapeutic effects.

Gene therapy and cancer

In cancer therapy, various genes are currently being used with different mechanisms of action. The greatest role is played

by genes which modulate the immune system. Attempts are made to stimulate *immune cells* (cells of immunological defense) that recognize and destroy *tumor cells*. Besides this, *suicide genes* are used. Tumor cells which express these genes die under the action of certain dru gs. This kind of drug sedisitization is already used in the treatment of melanomas, various brain tumors and colon cancer.

Other approaches are based on the expression of *tumor suppressor genes*, e.g. p53, the overexpression of which leads to *apoptosis* (natural cell death). The most recent approaches in gene therapy are exploring the use of *antisense DNA*, which is intended to suppress e.g. the expression of *protooncogenes* such as c-myc or factors of angiogenesis (angiostatin, endostatin).

The currently high expectations of immunotherapy have resulted from the constant increase in knowledge of the signals required for efficient immunostimulation. In the meantime, one is aware of the central importance of *immunological synapses*, i.e. the close contact between the antigen-presenting cell and the defense cell (T cell). However, the contact only leads to activation of the defense cell when a second signal arises via the interaction of *surface molecules* (B7) on the antigen-presenting cell and the receptor on the defense cell. Without this costimulation, the defense cells are not activated, but are in contrast inactivated.

Molecular investigations indicate that many tumor cells present antigens that can be recognized by specific receptors of the defense cells. For this purpose, the tumor cells usually express sufficient adhesion molecules in order to stabilize the immunological synapses mentioned above. However, most tumor cells lack the *costimulation molecules* that were also mentioned above, so that the defense cells are not activated. Irrespective of this, most tumor cells do not secrete any *substances promoting cell growth* (cytokines). This in turn prevents an immune response.

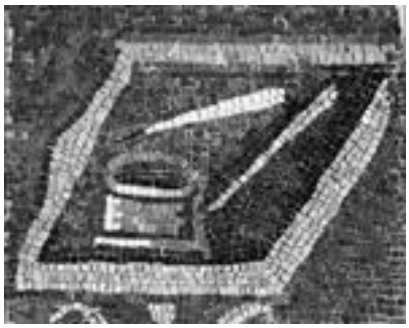
This definite information led to the attempt to convert tumor cells into cells presenting good antigens by gene modifications. For this purpose, genes for the costimulation molecule (e.g. B7) and various cytokine genes are introduced into the tumor cells and their expression is induced. These gene-modified tumor cells are then administered to the patient as *tumor cell vaccines* in the hope that the defense cells are activated via the antigen-specific signal in combination with the costimulation and the cytokine secretion so that the tumor is destroyed.

In our in-vivo and in-vitro investigations, we encountered two different gene-modified tumor cell lines in kidney cell carcinoma that express interleukin 2 and interleukin 7 in combination with the costimulation molecule B7. Both tumor cell lines have been available for some time in a multicenter clinical phase I study as a vaccine for treatment of metastatic kidney cell carcinoma.

In using gene-modified tumor cells as vaccines, the tumor cell is used as a carrier for the tumor antigens which obviates the need to identify antigens leading to immunostimulation. Tumor cells can produce *immunosuppressive factors* (e.g. inhibitory cytokines), so that no immunostimulation is possible despite the presence of antigens and also after gene modification of the tumor cells with costimulation molecules and activating cytokines. However, this is not the only problem in our research. There are further problems which have not yet been resolved today. For example, another drawback in the use of turnor cells as vaccines is the great expense in terms of equipment and time which is needed to produce an adequate number of cells for vaccination of many patients. Experience so far with cellular vaccines shows that the *cost factor* and the *elaborate technology* does not allow broad-scale application.

Limitations accelerate the development of new concepts of gene therapy. A promising concept is based on the introduction of immunostimulatory genes directly into the tumor. New technological and methodological challenges result from this kind of in-vivo gene therapy. For example, the *vectors* which have been tested so far and proved very suitable for in-vitro gene transfer (e.g. retroviral vectors) are not unsuitable for gene transfer in vivo, since these only effectively transfect dividing cells. New vector systems which are derived from herpes simplex viruses and similar viruses do not show these limitations and are currently under development.

In improving the efficiency of in-vivo gene transfer, criteria such as the *safety* of the vector system used, *regulation of gene expression* and *gene dose* must be considered. In this regard, *vector sys-*



tems are being created with tissue-specific and inducible promotors. A *prostate-specific expression* can be attained for example by using the promotor for the *prostate-specific antigen* (PSA). Promotors inducible with heat or promotors which are induced by means of *estrogens* or *tetracyclines* can also specifically switch therapeutic genes on and off.

Genes which code for cytokines, costimulation molecules or tumor antigens are suitable for in-vivo gene transfer. The use of *RNA* (ribonucleic acid) isolated from tumor material is also conceivable. These genes can be directly administered in vivo or also charged ex vivo on antigen-presenting cells. The data available up to now suggest that both a *humoral antibody response* and *cellular immunity* can be induced in an in-vivo injection.

Developments in recent years have enabled *ex-vivo charging* of antigen-presenting cells with *tumor antigens, tumor lysates* or *heat shock protein-peptide complexes* especially by creating the conditions for in-vitro culturing of

antigen-presenting cells. The *advantage* is that the modified antigen-presenting cells can be investigated for their immunostimulatory properties before they are injected into the patients. The *disadvantage* is that the tumor antigens or peptides must be known. For example, many antigens are already known in melanoma so that this concept is currently being tested with promising results in clinical studies. Knowledge of the relevant antigens for most other tumor types is still very scanty, so that the challenge of the future is to identify antigens relevant for other tumors.

Experience of the first clinical studies of vaccines produced from tumor cells altered by genetic engineering and in-vivo administration of tumor peptides shows that it is entirely possible to stimulate a clinically relevant antitumor immunoreactivity. However, at the same time it became evident that *tumor variants* arise under the selection pressure of the induced antitumor immune reaction which are resistant to the immune responses elicited. The mechanisms of this *immune escape* are multifarious and include turning off the expression of relevant tumor antigens, loss of antigen-presenting MHC molecules and the expression of immunoinhibitory factors.

These results underscore that the successful induction of *antitumor immune reaction* is only one parameter in the complex interaction between the tumor and the immune system. In the final analysis, long-term results with gene therapy can only be attained when the multifarious interactions between tumor and immune system are understood and we learn to modulate these interactions specifically. I have no doubt whatever that this will be successful. The only open question is how long it will take to achieve the breakthrough in the *climate inimical to research* with which genetic engineering is confronted.

With genetic engineering we have reached the frontiers of what is technically feasible in the struggle against cancer. It is now necessary to find the right approach taking into account the multiplicity of experience and new knowledge which will bring us closer to solving the problem of cancer.

Technical limits of gene therapy

The example from our cancer research has demonstrated the technical limits and our efforts to surmount them. These technical limits can be overcome. However, there are other more important limits, namely moral and ethical constraints which must be observed and which must focus on the value and the dignity of human life.

Dangers of technological progress

If we consider the progress in technology today in very general terms, it must be observed that the welfare and integrity of the individual human being is now often not the first priority of research. For whom is such research of benefit, for whose welfare and for what kind of human being?

Limits of progress

However great its scientific interest, any technological advance must be subject to morale constraints since personal integrity and dignity requires limits. Apart from this, I am convinced that what is regarded as "technological progress" cannot ultimately create anything new. All that it produces that is apparently *new* on the basis of painstaking experiments with failures and mistakes has already been predetermined. Despite all the successes of research, humanity will not succeed in a real creation, that is to say creating something from nothing, not even in the future. Notwithstanding all technological progress, humans will always only be discoverers and possibly inventors, but never creators.

Research as a human mission

We know from the first page of the Bible that God called on human beings to care for *His* creation while observing *His* laws. Creation is hierarchical. At the top is the human being and his inner vocation – for the nonbeliever – but for the believer the human being and his divine calling. For this reason, technology should never produce anything which destroys the integrity of the human being, his natural development and his personal dignity. This is a maxim against which every technological advance must be measured.

The task of technology is to serve humanity, the individual human being and especially those who feel marginalized owing to debility and disease. If research loses sight of this objective and succumbs to "creative delusions", this would rapidly transform the benefits of research so that they become detrimental. I believe that the limits of technological progress in medicine are well defined by the words of the *Holy Father* on the Day of the Sick Person on 11th February 2000: "Research and technology must avoid creating new forms of alienation for the weak, the elderly and the incurably ill". In complete agreement with the Pope I would like to erect a boundary stone for technology, especially for my specialty, *medical research.*

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II: Dehumanization in Intramural and Extramural Health Care, its Underlying Causes and Expectations for the Future

Introduction

The themes of this international conference on health care and society are: technological challenges and the humanization of medicine. The latter indicates that at present treatment of patients is to a greater or lesser extent inhuman; there is a certain degree of dehumanization that ought to be redressed.

However, before we can speak successfully about the humanization of medical treatment, it is first necessary to define dehumanization, to survey broadly its manifestations and to investigate by what they were and are caused. I shall do this by speaking about dehumanization in medical practice and medical care in general. Where and when this evil concerns intramural or extramural care will be evident to everybody. In the second place, I will confine myself in this lecture to the Western industrialized world, because the problem originated there, even though sooner or later the Third World will also be faced with it.

1. What is dehumanization?

What do we mean by dehumanization? Briefly speaking, it is a degradation of the human person. Every human being, every patient is a person from the fertilized egg (zygote) and remains one until death, however miserable his mental or physical condition may sometimes be. As a human person he has an intrinsic dignity, a dignity which does not derive from his physical or mental health, but exclusively from the fact that he was created in God's image.

This dignity also entitles him to respect. In fact, dehumaniziation is nothing but not respecting the other person in his otherness[1] and especially with reference to our subject: not respecting the patient as a person in his sickness.

The degradation of a patient manifests itself in many forms and may vary from paying insufficient attention to him or giving him insufficient care to regarding him as an animal or a thing, an object that may be used as a means to an end and which may, if necessary, be destroyed or helped to kill itself.

2. Cause of dehumanization

On closer inspection virtually all cases of dehumanization appear to have their origins in the spectacular scientific progress and technological developments of the last century, the influence of the economy, increasing bureaucracy and, possibly the most important factor, the ongoing process of secularization in society and consequently also in medicine.

There is no denying that present health care is rapidly technologizing. In the first place in the hospitals with their high tech provisions for transplants of practically all organs, intensive care, prenatal diagnostics and artificial insemination, and soon perhaps the makable, or, because of new discoveries in genetics, the clonable man, to mention just a few.

When we speak about the technologizing of health care, the word itself has a negative undertone. In itself, that is not right, for if we mean by technology the use of tools to make things outside ourselves fit for human purposes, technology in itself may very well serve man and nature and even be an enrichment to our culture as Pope John Paul II says in his encyclical *Laborem Exercens.*[2]

However, since Francis Bacon (1561-1626), the first advocate of organized scientific research for the ultimate purpose of subjecting nature, the originally Christian Western culture has gradually become a secularized culture under the influence of the progress of science and modern technology. A culture which would prefer to tackle all problems – including medical ones – in a technical way

and which at times does not shrink from using even euthanasia as a technical solution to end human suffering. In other words, it has become a culture that may be called technicistic.[3] By technicism we mean man's presumption to manage all reality as lord and master with the aid of the scientific and technological method of control in order to solve all old and new problems in this way and thus to guarantee growing material prosperity – progress.[4]

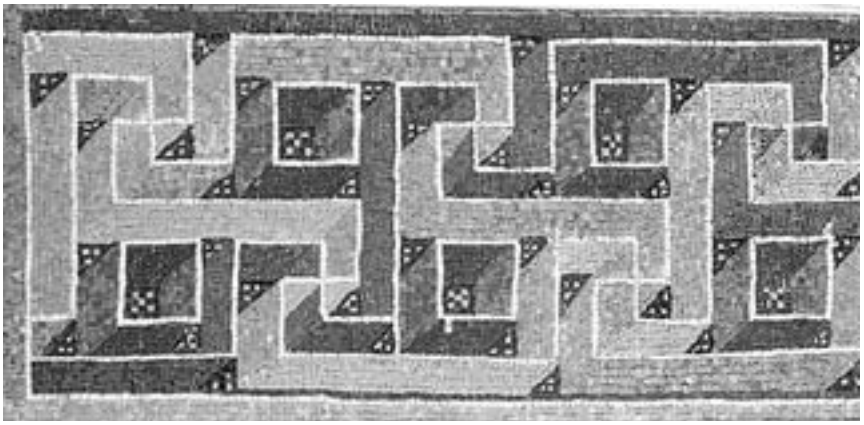
Here, too, the connection becomes apparent between secularization (which is actually desacralization) and technicism: Western man accepts less and less that he lives in a reality created by God. On the contrary, he thinks this reality only becomes meaningful by applying his technology to it and by making improvements.

Closely related to technologization in general – and to that of health care in particular – is its economization.

It is a well-known fact that under the influence of the First Industrial Revolution in the late eighteenth century and the resulting rationalization, technologization and economization, 16th. and 17th. century mercantile capitalism changed into the liberal capitalist market economy.[5] This liberal capitalism, which has developed into financial capitalism over the last few decades, flourished especially in the countries where the influence of Protestantism was strong, such as England, Holland and later also in America, notably through the cotton and slave trade.

In fact, this market economy was made possible only by a desire to control things by technical means. Fascinated by the results of rationalized processes in trade and industry, governments started also to apply them to health care, where costs rise considerably every year as a result of the purchase of more and more expensive equipment, the higher wages of the workers and the increased demand for care (amongst other things caused by the so-called doubled increase of the ageing population).

The consequences of this economization and rationalization of health care were and are disastrous to both patients and doctors and nursing staff, especially in hospitals. Hospitals are regarded as commercial enterprises that must obey the criteria of profit. Just a few examples: the care given has become a *product* and the patient a *customer*; the quality of the product that is to be delivered must be measured, must be produced as cheaply and efficiently as possible according to a set protocol so that it will fit within an approved budget. The consequences of all this are, among other things, an increasing bureaucracy caused by the appointment of so-called *care managers* and *stopwatch care* through imposing time limits on treatments and care given by nurses.



It is understandable that the quality of the care given is measured, but it is ominous that they have gone further and now also want to determine the quality of the patient's life. But this, too, is a direct consequence of rapidly spreading desacralization. For a Christian, human life has only one qualification, namely that it is sacred. The postmodern manager, on the other hand, wishes to express in measure and number what a certain patient's life is still worth with a view to starting or not starting a treatment. That is why from an economic point of view a cost-benefit or cost-effectiveness study is made and calculations are made in QUALY's[6, 7] which a patient must score before he can get a certain treatment or test. QUALY is short for Quality Adjusted Life-Year, in which two elements have been joined: life-expectancy (in years) and the quality of this life, which also involves an estimation of the restoration of his productivity.

History teaches us that speaking about the (remaining) value of a human life is not new. As early as 1920, a publication by Binding and Hoche, a lawyer and a psychiatrist respectively, appeared in Germany entitled: 'Die Freigabe der Vernichtung lebensunwerten Lebens'.[8] Translated into English: 'The release of the destruction of life devoid of value'. This was the first time that the quality of life had been openly written about.

There is no need to explain how the economization and the rationalization of health care inevitably had to lead to dehumanizing utilitarian ethics.

If we look for the deeper causes of this dehumanization, as a result of which less than full justice is done to man's dignity in medical actions nowadays, especially in the industrialized Western countries, we are forced to conclude with Weber that the seeds of 20th. century capitalism, of present-day technicism and of economization (and of our whole present-day political philosophy) were sown in the Reformation and notably in Calvinism.[9] Consequently the resulting dehumanization in medicine, in my view, has its origins in the religious doctrine propagated by Protestantism. This position requires further explanation.

The Reformation occurred in the 16th century as a reaction to the decay and the corruption within the Roman Catholic

Church. Calvin (1509-1564) preached – contrary to the preaching of all the previous centuries – that Holy Scripture is the sole source for faith and that man can be saved only through faith. Furthermore, man can only accept this faith if he is predestined by God to do this by means of His grace. The experience of faith then became a non-sensory, abstract and mental, solely rational (or, on the contrary, irrational) matter. Not only faith, but also moral values thus became a subjective matter and multi-interpretable.

The loss of the sacrality that could be experienced through the senses and thus the feeling for what is sacred and holy, stemmed from the denial of the real presence of Christ in the Eucharist, the abolition of all sacraments (save Baptism) and the almost total reduction of the splendour of the liturgy and the paraliturgy. Church offices, too, such as the office of minister, were desecrated by opening them up to ordinary citizens. With desecration, which deprives the world of the appeal of holiness, secularization inevitably creeps into Calvinist theology.

Inevitably, because the Calvinists were thrown upon their own resources to prove their predestined status, for it was only through success in their work (i.e. material prosperity) that they knew that God blessed their work and that they could be certain of their salvation.

Contrary to the Roman Catholic Church, Calvin denied the use and the necessity of good deeds because faith alone had restored the bond between God and man.

But not only good deeds were lost as a means of salvation, work as a whole was desecrated, desacralized (and ultimately overrationalized) for, so they reasoned, if good deeds cannot hallow man, in the light of predestination, evil deeds cannot damn him. It was therefore not surprising that, partly as a consequence of their autonomous ethics, all sorts of things (such as the slave trade) were justified, for if so much profit could be made, God's blessing was bound to rest on them. Who, then, were these Calvinists, also called Huguenots in France? The social class from which the first adherents to Calvinism in France came, was the middle class: civil servants, scientists, merchants, artisans and bankers.[10] When the persecution of these Protestants began in France, many fled the country.

It was not just anybody that left, for everywhere they settled, technology and trade flourished. This progress was so remarkable that many are inclined to view not Adam Smith and his book 'Inquiry into the nature and the causes of the wealth of nations', published in 1776, as the founder of the classical school of economic liberalism, but the Calvinists.

Most of them went to Switzerland, Germany, Denmark, Sweden, England and especially to the then Holland, where they were hospitably received and had many followers. From here and from England a large number emigrated to America, and one of the places where they settled was by the mouth of the Hudson River, the present New York. Later, when they had become rich colonists, they mingled with the local population. Together with other Protestant groups, such as Presbyterians, Baptists and Methodists, they also entered politics and not without success: they contributed to the American Declaration of Independence of Thomas Jefferson on Independence Day (July 4th, 1776), among other things, and nine Presidents rose from their ranks. It was especially this group of colonists and their descendants that – deliberately or not – instigated the development of the present-day financial and capitalist ideology and the global economy that spread globally from the United States. In other words: present-day capitalism with all its excesses stems from Protestant individualism.

It is, consequently, not a bold proposition that the underlying cause of the present dehumanization in general and of health care in particular is the rise of Calvinism and not, as is often thought, the Enlightenment, which only served as a catalyst. This thesis is also supported, in my view, by the fact that the Netherlands, the country where Calvinism had a great many adherents, was the first nation to permit and legally regulate euthanasia.

3. Humanization of health care

If we are to rehumanize health care, we shall have to bear in mind that we are living in a post-modern culture, a transitional culture from the industrial, modern age to an information society. Fukuyama describes this transition as a clear break with the past, a great disruption, characterized by a breakdown of the social values in the society of the middle of the last century.[11] He points out that these moral values and social rules, which he and other sociologists call 'social capital', are not simply restrictions on individual freedom of choice, but the main condition for any co-operative venture.[12] Fukuyama is also convinced that people – because they are in his view autonomous – will be capable on their own of drawing up new rules which will improve the present situation again. However, this is a view which I cannot share.

Not only because it is baselessly optimistic about the makability of the moral reality, but especially because morality without God is an idle concept which at best leads to moralism. Only a true Christian faith can liberate man from sin and make him truly free. What is needed, therefore, is re-evangelization, so that God, and thus the sacred, can be given a central place again.

The greatest hindrance to (re-) evangelization is not so much the resistance Christianity meets, nor the presence of other 'competitive' religions, but rather the indifference which comes from anti-doctrinal post-modern relativism which increasingly tends to emotionalism. Consequently, Christianity will not be able to convince present-day man by means of a theoretical approach. Maybe the world will be struck again by the faith of the Christians, notably those who are ac-

tive in health care, if in their work and in their faith they bear witness to something that has made them profoundly happy and free.

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Notes

[1] G. CHANTRAINE S.J., *Zieken begeleiden in een pluralistische wereld,* in: Communio, Oudenaarde (1997), nr. 4, p. 267.
[2] POPE JOHN PAUL II in: *Encyclical Laborem Exercens,* Vatican City (1980), par. 5.
[3] E. SCHUURMAN, *Gebven in wetenschap en techniek (Belief in science and technique),* Amsterdam: Buijtenen Schipperheijn, 1998, p. 59.
[4] E. SCHUURMAN, *Identiteit of uniciteit (Identity or unicity)* in: Pro Vita Humana (1998), 4, pp.10-11.
[5] In the days of mercantile capitalism money was still a means and not an end in itself as in financial capitalism.
[6] E. SGRECCIA, *Respect for Life and the Search for the Quality of Life in Medicine: Ethical Aspects,* in: Dolentium Hominum, Vatican City (1995), nr. 28, pp. 154-160.
[7] W. EIJK, *Ethical Models for Health Management,* in: Dolentium Hominum, Vatican City (1998), nr. 37, p. 59.
[8] K. BINDING und A. HOCHE, *Die Freigabe der Vernichtung lebensunwerten Lebens (The Release of the Destruction of Life Devoid of Value),* Leipzig: Felix Meiner 1920.
[9] MAX WEBER, *The Protestant Ethic and the Spirit of Capitalism,* London: Allen and Unwin, 1930.
[10] I. and K. BRANDENBURG, *De Hugenoten (The Huguenots),* Amsterdam: De Bataafse Leeuw, 1992, p. 9.
[11] F. FUKUYAMA, *De grote scheuring (The Great Disruption),* Amsterdam/Antwerp: Contact, 1999, p.17.
[12] Ibid. p.26.

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III: The New Health Care Workers

Human resources – the different kinds of clinical and non-clinical staff who make each individual and public health intervention happen – are the most important of the health systems inputs. The performance of health care systems depends ultimately on the knowledge, skills and people responsible for delivering services.[1]

Working context

Before further discussing human resources it may be helpful to briefly outline the environments in which health care providers work.

Health status

The health status of the population differs substantially across the world. Countries such as Canada, the United States of America, most of the countries of Western and Central Europe, Australia, New Zealand and Japan have low levels of child mortality and both male and female adult mortality. For example, the probability of dying under age 5 years for males in Canada in 1999 was 6 per 1000 and 5 per 1000 for females. The figures for Germany were the same as for Canada, and similarly New Zealand's figures were 9 per 1000 for males and 7 per 1000 for females.

In stark contrast, countries in sub-Saharan Africa had high levels of both child and adult mortality. Most of these countries also experienced extremely high levels of female mortality, attributable in large part to AIDS.[2] The probability of dying under age 5 for males and females in Mali in 1999 was 240 per 1000 and 229 per 1000, respectively; in Malawi the figures were 222 per 1000 for males and 215 for females.[1]

A report to the 105th Executive Board meeting of the World Health Organization states: "Mortality has declined across the globe, for both children and adults, yet heterogeneity in the rates of decline appears to be increasing, with reversals in some of the poorest parts of the world."[2]

WHO argues that mortality alone is insufficient as a measure of health. WHO uses the criterion of health expectancy, measured through disability-adjusted life expectancy, which takes into account not only premature mortality but also time spent in health states that are less than full health. The main causes of ill health can be grouped into three categories: 1) injuries; 2) noncommunicable diseases; and 3) communicable, maternal, perinatal and nutritional diseases. While the major causes of ill health in the WHO African region are in the third category, the Americas, Europe and the Western Pacific are dominated by noncommunicable diseases.

WHO has developed health scenarios in order to assist policymakers in the health sector in making decisions about investment in human capital, physical infrastructure, and research and development. One such scenario suggests that "the leading causes

of the global burden of disease are expected to change from a pattern dominated by the communicable disease killers of poor children to a pattern dominated by non-communicable diseases and injuries. Projected leading causes will include ischaemic heart disease, depression and road traffic accidents followed by stroke, obstructive pulmonary disease and then lower respiratory infections, tuberculosis, possibly war, diarrhoeal diseases and HIV/AIDS."[2]

Health system reform

Most developing countries and countries in transition have undergone and are undergoing processes of health sector reform. External forces due largely to macroeconomic conditions have stimulated these reforms. Civil service reforms and the restructuring of economic institutions in compliance with requirements of the International Monetary Fund and the World Bank are intended to achieve efficiencies in different sectors. Reforms typically aim to improve equity, effectiveness, efficiency and the satisfaction of users.[3, 1]

Bennett *et al.* in their 1997 book *Private health providers in developing countries*[4], identify the reform agenda promoted by the World Bank in *Financing health care: an agenda for reform* (World Bank 1987) as that of a smaller role for governments. This has taken the form of increased private-sector activity, such as contracting for health care services (in the United Kingdom), increased competition among providers, managed markets, autonomous hospitals and growth in private hospitals. Decentralization has also been identified as a stimulus for growth of the private sector.

These reforms have often had unintended consequences for the health sector, especially for the poor. A "Round Table on Public Service Reforms and their Impact on Health Sector Personnel", hosted by the German Foundation for International Development and co-sponsored by the International Labour Organisation and the World Health Organization, found the following impact on health workers:[5]

– downward pressure on wages (e.g. Cameroon, Uganda);

– unemployment of health personnel or low motivation due to uncertain employment conditions;

– labour unrest, expressed in slowdowns and strikes;

– migration of workers from the public sector to the private sector, often resulting in an overall reduction in the level of skill and competence in the public sector.

The changing health sector has had and will continue to have a significant impact on the way in which health workers are trained, the work they do and how they are organized and paid to do that work.

Globalization

The emigration of health personnel has been a major issue for both industrialized countries and developing countries for many years. Each year large number of doctors and nurses trained in developing countries leave. Adams and Kinnon[6] report that although skilled health personnel tend to go to the industrial countries of the North, there is also considerable South-South flow. In order to overcome its shortage of physicians, Ghana is recruiting physicians from Cuba on limited-term contracts between the two countries. Jamaica is recruiting nurses from African countries, including Ghana. James Buchan and Fiona O'May, in a study focused primarily on movement of nurses, conclude that: "the globalization of markets and the development of free trade blocs (e.g. North American Free Trade Agreement (NAFTA), European Union (EU), MERCOSUR), with associated free mobility of labour, represents a factor of significant and growing importance when examining the international mobility of nurses."[7]

The General Agreement on Trade in Services (GATS) defines four modes of trade: cross-border, movement of consumers, foreign commercial presence, and movement of persons supplying services. With regard to the latter, the loss of health personnel from needy countries to wealthier ones is already a serious problem. Adams and Kinnon also suggest that if barriers to this type of movement are reduced as a result of the GATS without an appropriate regulatory framework and improvement in working conditions in the domestic health system, equity, quality and efficiency will all suffer.

Globalization will also have an impact on health workers in other ways, such as the potential influx of foreign firms in the health sector and the demands they may place on the public domestic labour market. An increase in cross-border trade in health services such as telediagnosis and telemedicine via information technology will have an impact on education and training and on the availability of support to health care workers in non-urban areas.

The environment in which health workers are educated and trained and in which they live, work and are themselves consumers of health services, has a profound impact on their morale, motivation and productivity. The production of health workers of different types, although often driven by professional interests, should in part be a function of the health conditions in the county, the macroeconomic changes, the health sector reforms, and the broader global changes. There is little research on the relative importance of these different environmental factors.

Current issues for human resources for health

Poor working conditions, inade-

quate pay, lack of appropriate incentives, poor management and shortages of working materials such as essential medicines and consumables, are among the most pressing problems facing health workers in developing countries.[8, 9, 1, 10] This translates into imbalances in human resources for health in most developing countries. Adams and Hirschfeld[8] divide these imbalances into four categories:

– *Imbalances in overall numbers*: differences between the number of health care providers of various categories and the numbers a country or community needs and can afford;

– *Imbalances in skills or skill mix*: a mismatch between the type or level of training and the skills required by the health system;

– *Imbalances in distribution*: a mismatch in geographical, occupational, public/private, institutional or specialty mix;

– *Imbalance between human resources for health policies and the national health policy*: a mismatch in the priorities of the health system and the training or employment of the appropriate health workers.

These imbalances appear to be chronic problems in most developing countries, if not all. While shortages of health care professionals have been reported in most countries of the world, whether industrialized or developing, shortages appear to be more severe in Africa and Asia. A survey of 40 countries conducted by WHO and 18 in-depth country case studies prepared by country teams in all WHO regions found that each category of imbalances can take different forms in the different regions and countries. For example, in Africa the cause of the problem appears to be low training capacity and very low pay, which result in retention and production problems. In the WHO South-East Asia region, the problem is due more to poor distribution than to production. Health workers are often reluctant to practise in rural areas.

The issues facing policy-makers and managers in ensuring appropriate investment in health workers are affected by many complex factors. Some of these factors have been discussed above. Gilles Dussault, formerly of the University of Montreal Faculty of Medicine and now with the World Bank, identifies the following environments that have an impact health worker development:[3]

– *Legal factors*: including the existing laws and regulations and the ways in which they are enforced.

– *Economic factors*: the availability of resources in both the public sector and the private sector, and the economic priorities of the government.

– *Organizational factors*: the distribution between the central, regional and local authorities of responsibilities and of power to make decisions. The number and nature of ministries involved in making policy are also important.

– *Technological factors*: this includes the use of new communications technologies such as the Internet and applications such as telemedicine. These tools can have a significant impact on education, training and practice.

– *Sociocultural factors*: the social status of the occupations is an important variable that carries with it a certain degree of power and political influence. The perception of male and female occupations is also influential.

– *Political factors*: the status of health issues on the agenda, the degree of political consensus as to the need for change, and the proximity of some health worker groups to the political process.

These environments, coupled with the many actors involved, such as the state, employers, producers, regulators, service providers, representative bodies, consumers and external funders,[11] make the development of health workers very difficult, complex and politically sensitive.

Who are the health workers?

There is a wide range of health workers, categorized by their level of education and training, the tasks they perform, the degree of autonomy of decision-making and the systems in which they work. Health workers can be found in the public sector, the private for-profit sector and the private not-for-profit sector. They work in the personal provision subsector of the health system and in the population subsector of provision. The latter group is often referred to as public health providers.

Health workers are also found in the voluntary sector. Traditionally the providers of health care at home have been women, who care for children and the elderly. This type of care can be considered voluntary care. A report prepared by WHO for the World Health Assembly, May, 1997, examined the state of health professionals other than nurses and doctors (the two categories most commonly identified). The report states that "the number of health personnel other than doctors, nurses and midwives can vary from one country to another from a dozen to several hundred. In the United States of America, as an example, there are about 250 different types of allied health personnel alone. Tables 1 and 2 show the wide range of categories of health personnel and the variation that occurs from country to country as exemplified by data from the WHO Eastern Mediterranean and South-East Asia regions."[12]

The report demonstrates how differences in nomenclature and classification from one country to another make intercountry comparisons of health workers very difficult. Designations can be misleading: a given category of health personnel can have different training and responsibilities in differ-

Table 1: Distribution of various health personnel in the South-East Asia Region

Category	Bhutan	Indonesia	Myanmar	Sri Lanka	Thailand
Medical laboratory technologists (MLT)		X	X	X	X
Laboratory technicians	X	X	X		X
Radiographers	X	X	X	X	
Physiotherapists	X	X	X	X	
Occupational therapists				X	
Pharmacists	X	X	X	X	X
Dental technicians/assistants	X	X		X	X
Entomological assistants				X	
School dental therapists (nurses)		X		X	
Public health inspectors (supervisors)			X	X	
Lady health visitors			X		
Microscopists				X	
EEG recordists				X	
ECG recordists				X	
Compounders (dispensers)		X	X		
Auxiliary midwives			X		
Health assistants	X		X	X	
Community health workers	X				
Basic health workers	X		X		
Nutritionists/assistant nutritionists		X		X	
Medical records staff		X		X	

Source: World Health Organization Regional Office for South-East Asia

Table 2: List of health care providers in the Eastern Mediterranean

Professionals	**Paramedicals/technicians**	**Auxiliaries**
Physicians	Assistant pharmacists	Medical orderlies/aides
Dentists	Medical health assistants	Sanitary assistants
Pharmacists	Physiotherapists	Medical records clerks/card clerks
Graduate nurses	Sanitarians	Community health workers
Physiotherapists	Radiographers	Traditional birth attendants
Environmental health officers	Laboratory technicians	Lady health visitors
Laboratory technologists	Refractionists	Vaccinators
Medical records officers	Medical records technicians /assistant medical records technicians	Herbalists
Statistics officers	CSSD technicians	Traditional healers
Nutritionists	Dental technicians	
Medical equipment engineers	Statistics technicians	
Medical social workers	Audiometricians	
Psychologists	ECG technicians	
Microbiologists	EEG technicians	
Biochemists	Operating-room assistants	
	Dietitians	
	Prosthetics technicians	
	Medical equipment technicians	
	Dental prosthetics technicians	
	Food technologists	
	Anaesthetics/ICU technicians	

This list is illustrative but not necessarily exhaustive.
Source: World Health Organization Regional Office for the Eastern Mediterranean

ent countries. And categories of health personnel have been adapted to evolving needs and priorities and new job opportunities, either by changing their designations or by modifying the focus of their work.

Examples can be found in such diverse places as Latin America, Pakistan and the Russian Federation. In several Latin American countries, primary health care workers have been specifically trained to help improve environmental sanitation, a move that was

stimulated by an outbreak of cholera in the region. In Pakistan and Bhutan large numbers of female family health visitors have been trained in order to improve access to health care by households in remote areas. In Russia, feldshers – whose role as medical assistants and public health workers mainly in rural areas has been well known for decades – have now assumed new functions such as staffing emergency care units in big cities or serving as occupational health officers in factories.

The report further discusses the spectrum of the responsibilities of health workers: promotive, preventive, curative and rehabilitative services. In some cases, promotive and preventive services constitute the major part of the work of some categories of health personnel (e.g. public health inspectors, health educators, environmental health officers). Community-based rehabilitative care is increasing in importance with a growing elderly population, an increasing burden of chronic and degenerative diseases, mental disorders and accidents.

At the same time as we see a growth in community-based providers, there is also an increase in specialization in the more developed countries. This results in part from the increase in medical technology and scientific knowledge.

As health systems try to respond to demographic, epidemiological and technological changes a greater emphasis is being placed on other professionals such as social workers, school health educators, nutritionists, environmentalists and other providers more associated with prevention rather than cure.

In many developing countries there is a well-established number of traditional health providers. There is an attempt in some African countries (e.g. Ghana and Uganda) to more closely incorporate these providers in the health system by developing mechanisms to control standards of providers. In the industrialized countries there is an increase in the use of traditional medicines and providers such as acupuncturists, herbalists and massage therapists.

New health workers

Industrialized and developing countries alike have begun to use or consider using so-called "new" health workers, such as multiskilled "generic" care assistants, nurse practitioners, nurse anaesthetists and doctors' assistants. Buchan and Dal Poz[13] suggest that the new worker is in fact often an existing occupation or grade with additional skills or an expanded role. Many of these types of amended roles are in one of four categories:

– "multiskilling", or extended roles for a "traditional" support worker: catering, patient transport, cleaning and clerical duties;

– multiskilling – "cross training" – or extended roles for care assistants and auxiliaries (e.g. health community agents of the family health programme in Brazil);

– extended roles for current health care professionals (e.g. nurse practitioners);

– new technician roles (e.g. in surgery or anaesthesiology, as in Mozambique).

Conclusion

The development and use of health workers is affected by the context in which they work and the environments that define how and where, with how much autonomy and with whom they practise. Changing demographics, epidemiology and technology, as well as shortages and cost, have resulted in the creation of new categories of health workers. The introduction of these new workers has, however, often not been based on careful study and evidence of the effectiveness of the new category.

There is a need to map the current situation with regard to the introduction of new workers. Their impact on patient care and cost-effectiveness should be assessed. In addition, the different rationales and methods for introducing new workers must be analysed in order to determine what works and what does not, and under what conditions.

WHO is embarking on a two-year programme to develop the knowledge base on the implementation and impact of introducing "new" workers in health systems. This effort is intended to result in decision-making tools to assist policy-makers, health systems managers and health workers to determine the likely impact of introducing specific types of new workers and to identify and help weigh options on effective methods of introduction.

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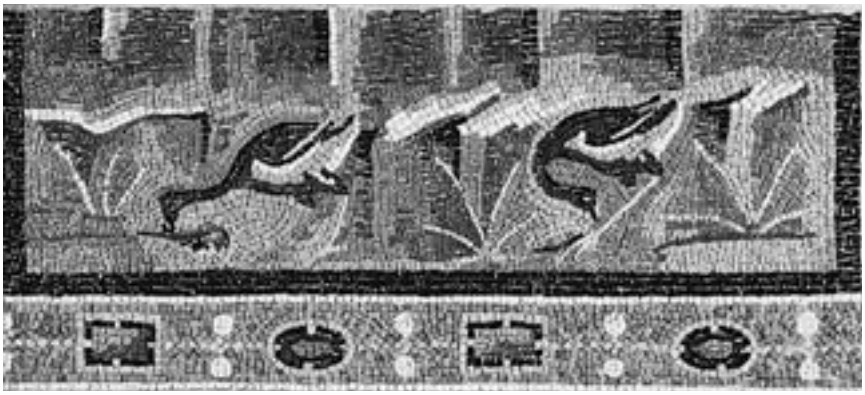

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MARY HEALEY-SEDUTTO

IV: New Emerging Infectious Diseases: The Globalized Public Health Crisis of the New Millennium

As we rapidly approach the closure of our Jubilee Year 2000, it is most appropriate that we now look towards the health of our society with a futuristic eye, and challenge ourselves to envision how we, as Church, need to give witness to our beliefs through actions which will advance the well-being and health of our globalized family of mankind. When our Holy Father addressed us on February 11, 2000, he so beautifully and so simply reminded us that, "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."[1] We who have been given the gift of being permitted to serve in the healing ministry of Jesus need to challenge ourselves and creatively look at how we, too, can 'stop, bend down and share'.

Back in 1993, the California film industry produced a movie entitled *Demolition Man*, which for painfully obvious reasons, was not a great success in American theatres. Yet in many ways, it was hauntingly prophetic in its vision of what the world would be in the year 2032. *Demolition Man* takes us on a futuristic journey in time, to a place in southern California where the forces of unchecked globalization have firmly taken control. It is a time with little genuine joy or humor or happiness. According to the film makers, in the year 2032 there were extraordinary limitations on personal freedoms, including the fact that it was illegal to have children without a permit. Why? Because a fully globalized society had become so fragile, extreme government control was seen as the only solution to the threat of complete global collapse. The movie proceeds to show us how society evolved, homogenizing, standardizing and sanitizing itself, and it becomes clear to the viewer that the forces of globalization had profound political, economic, societal, ethical and public health consequences.

While *Demolition Man* was a satire, its message remains a valid one. The impact of globalization on society – specifically on the public health of society – poses significant justice, ethical and economic questions for the international community. As the number of people living in and traveling freely throughout the world increases, and many of our megacities have pronounced overcrowding and poor sanitation; as we increasingly alter our natural environments and their climates and genetically manipulate our livestock and food chains; as we rapidly transition peoples into areas of exposure to diseases previously unknown to them and increase insect vectors into greater areas of population density, we accelerate the overall phenomenon of globalization and experience both its advantages and disadvantages.

The Good News and the Bad News of Globalization

Professors Alan Feranil[2] and David Fidler[3] of the United States remind us that while globalization has resulted in greater sharing of medical knowledge and technology and the removal of many international barriers, it has also opened a Pandora's box with its detrimental effects on public health. International travel is now fast paced, and diseases traditionally confined to specific regions are being transported by the traveler to far distant lands. The global nature of food processing, handling and distribution have exposed the entire world to microorganisms previously indigenous and limited to restricted parts of the globe. Regional overpopulation and overcrowding lead directly to poor sanitation and the spread of communicable diseases. As a result, both scientists contend that globalization has shattered the traditional distinctions between national and international public health, and while they cite many examples of why they feel this way, the most compelling perhaps is their reference to the global crisis of emerging and re-emerging infectious diseases. It is precisely about this topic that we will be speaking today.

Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases of the United States, a noted epidemiologist and infectious disease specialist, was scheduled to be here with us today. Unfortunately scheduling difficulties arose, and clearly I am not Dr. Anthony Fauci. However, his message to us were he here, would I am sure be one of caution, as he has repeatedly stated that he feels that mutated microbes, resistant to increased numbers of drugs, represent the real crisis for our new millennium. Alarmed by the African and Asian AIDS epidemics, Dr. Fauci's agency has dedicated over half of its total HIV spending budget towards the development of an AIDS vaccine. While he personally is optimistic that a moderately effective AIDS vaccine will be available within the next decade, he does not speak about its cost or global availability.

Cases of yellow fever which appeared in both the United States and Switzerland in 1996, were traced to tourists who traveled to yellow fever endemic regions without the necessary yellow fever vaccinations. Upon return to their countries of origin, they brought with them a disease most infectious disease specialists thought to be long eradicated in these countries. This case example is sadly becoming all too common place.

In the summers of both 1999 and 2000, New York City and surrounding areas saw the emergence of West Nile Fever disease, a mosquito borne encephalitis, which has caused the death of over 10,000 birds and other animals as well as seven elderly people. Epidemiologists have traced the virus to travelers visiting from Africa. This very same virus is now close to epidemic proportion in Israel, with eight deaths and over 120 confirmed cases diagnosed with the disease. In New York City, widespread aerial and ground spraying of insecticides every two to three days throughout the summer months has placed a financial strain on the local public health budgets in these regions, to say nothing of the disruption caused to normal living. As residents of the area, we were advised to turn off air conditioning, close all windows, stay in doors and not even allow our pets to be near the areas impacted by the spraying. The discouraging news is that the vector of disease identification in 2000 was far greater than that found in 1999, and public health officials are already trying to figure out what they can do for the summer of 2001. And while in the beginning only the elderly and frail were found to be infected, most recently diagnosed cases include several middle aged, otherwise healthy individuals.

Yellow Fever and West Nile Fever are but two examples of how globalized travel has resulted in disease transmission from third world countries to first world countries[4]. Clearly much needs to be done to better educate international travelers as well as public health controls and policies governing international travel.

What are EIDs and what are the Factors Contributing to their Proliferation?

Emerging infectious diseases or *EID*s are diseases which result from newly identified infections, both viral and bacterial, with the potential for causing public health problems either locally, nationally or internationally. The human immunodeficiency virus (HIV) which causes AIDS was first isolated in 1983 as an EID, and by June of 1998 (only 15 years later) it was estimated that 30.6 million people worldwide were infected and the life expectancy for babies born in sub-Saharan Africa is now less than 40 years.[5]

A new variant of Creutzfeldt-Jakob disease was first identified in the United Kingdom in 1996 and is thought to be the same agent responsible for the bovine spongiform encephalitis or "mad cow disease" epidemic of the 1980s, which affected thousands of cattle throughout the United Kingdom and Europe. The significance of this particular viral mutation is that diseases, initially known harmful and thought to be limited to animals, evolve to become known dangers to humans as well. It is also significant that what began in England quickly spread throughout all of Europe. One of the many effects of globalization has been the destruction of trade and commerce barriers. It is sobering to remember that 70% of all the fruits and vegetables consumed in the United States are imported from developing countries and that over 45% of all the fish consumed internationally comes from developing countries. There can no longer be a comfort level about food handling and processing practices specific to a single nation. National boundaries are fast becoming meaningless.

Not only are we seeing the emergence of new viral and bacterial diseases, we are also experiencing a rapid growth in the number of bacteria which are now dangerously and increasingly resistant to an alarming range of an-

tibiotics. Escherichia coli, Neisseria gonorrhera, pneumococcus and staphylococcus aureus often no longer respond to the lower cost drugs of traditional first line defense. The resultant effects of such viral and bacterial mutations is a longer and more costly treatment regime, often out of the reach of the majority of people living in third world countries. The burdens on third world countries in obtaining access to appropriate and adequate supplies of therapeutic drugs and vaccines are now being exponentially compounded by the effects of such mutations. But the effects of microbial mutation are felt in developed nations as well. In the United States, over 14,000 people die each year from drug resistant microbial nosocomial infections – those infections which are acquired in hospitals secondary to the reason for the hospitalization.

The mutation of viral and bacterial strains is closely related to yet another problem: that of too much and too little. In first world countries we see a very disturbing pattern of overutilization and inappropriate utilization of antibiotics. In the United States and Western European countries we see very alarming patterns of physician prescriptions for antibiotics where there is often no real evidence supporting the appropriateness of the medication. Patients go to their physicians with a complaint and expect to leave with a prescription. The President of the American Medical Association, Dr. Randolf Smoak, Jr., sadly admits that when physicians are "pushed and pressed to see patients more rapidly, it's a great temptation to just write an antibiotic prescription rather than spend five minutes explaining to a mother why it might be better in the long term not to prescribe it".[6] Even in cases where patients are told that their illness is viral, such as a cold or flu, where antibiotics will not be helpful, patients still insist on receiving a prescription for them. A microbiologist for the pharmaceutical company Eli Lily has recently completed research which indicates that over 40% of the antibiotics prescribed for respiratory and ear infections are inappropriate and that more than 90% of the staph aureus strains are now resistant to penicillin and related antibiotics.[7]

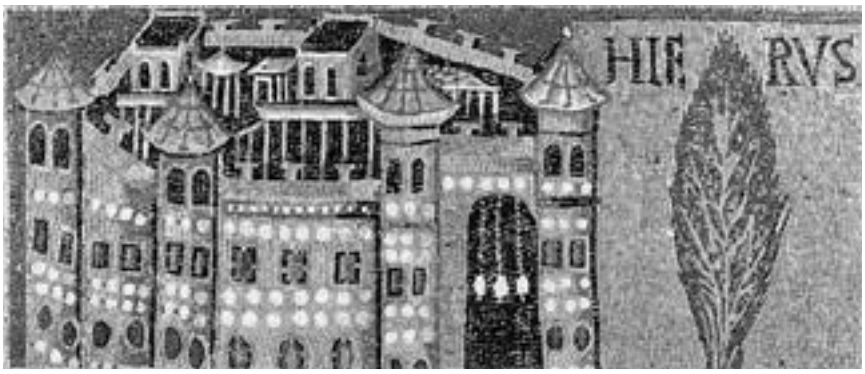
In third world countries we see an inappropriate utilization and under-utilization. It is all too common to find that many of the peoples who live in third world countries buy their drugs from local "drug shops" where the amount of medication they purchase is insufficient for the necessary length of treatment, and the quality of the drugs themselves leave a great deal to be desired. Taking medications for only two to three days until the outwardly visible symptoms are abated is often the practice for the medically and financially poor, and such practices simply allow the diseases from which they suffer to fulminate into even stronger sources of infection – recurrent infections which may not respond any longer to the initial – and preferred – and less expensive – drugs of choice. Many of these for-profit and privately operated "drug shops" will contend that they sell these drugs full well knowing that a longer treatment regimen is needed, but do so because the patient can only afford to buy drugs for a one or two day regimen.

While some relief with regards to the unavailability of drugs in third world countries has recently been promised, such as the commitment of Merck & Company to provide $100 million of vaccine to the poorest children in Sub-Sahara Africa and South East Asia,[8] the challenges still far outweigh the solutions. Together with Merck & Company, Smith Kline Beecham, American Home Products, and Aventis have all promised that they will increase their research and development efforts in their search for new vaccines. The Global Alliance for Vaccines and Immunizations, a not-for-profit organization supporting such efforts, recognizes that it will take the combined effort of government, industry and philanthropy to ensure that new vaccines are developed rapidly and brought to the market at prices which are affordable to those most in need.

A third, and perhaps the most troubling aspect of EIDs, is that which is associated with environmental or climate changes. Rift Valley Fever is a disease which principally affects cattle and sheep and is predominately found in Africa. People in contact with infected animals themselves become infected and in turn suffer from retinitis, encephalitis, hemorrhage, blindness and ultimate death. In 1997 and 1998, Kenya and Somalia suffered unusually heavy rainfalls, and this change in climate and environment affected the livestock of these countries, directly resulting in vast outbreaks of this disease. Dengue fever, known to be a major problem in South East Asia since the mid 1950s, has now re-emerged with a vengeance in Central and South America in the 1990s, and by 1997 epidemics were identified in 24 countries. In 1998, during a brief trip to Costa Rica, I had an opportunity to meet with government public health officials, and one of their chief concerns at the time of my visit was how to provide medications for the people in a remote and mountainous village where an outbreak of Dengue had erupted. As our global temperature rises, diseases which were limited to certain warmer, more tropical regions, are now spreading up the mountains into lands which were previously too cool to support mosquito infestations, mosquitos often

being the mode of transmission of the diseases in question. Countries already challenged by the costs of maintaining active mosquito control in traditional high-risk areas, simply cannot handle the costs of expanding their programs to greater geographic coverage.

And as if the above problems were not enough, we additionally must contend with the growing practice of feeding livestock low



levels of antibiotics to promote greater and faster growth. This practice results in the ability of bacteria, viruses and parasites to become drug resistant in these animals, mutating and surviving and then infecting humans. Recognizing the effects of the globalized destruction of many international trade barriers, the European Union has identified the alarming potential for continent-wide epidemics and has already banned the use of several antibiotics and feed supplements. But in the United States, the Food and Drug Administration has been slower to react, to a large degree as a result of great lobbying pressure from the pharmaceutical and livestock industries. Economic considerations and price protection policies appear to be outweighing national and international public health concerns.

The focus of the 1996 World Health Organization (WHO) Report was the globalized nature of emerging infectious diseases.[9] While WHO points to the significant progress the world community has made following World War II in battling infectious diseases and bringing to market new antibiotics, they are not quite as glowing in their optimism for the future. Their conclusion that infectious diseases will be controlled if current efforts continue to be maintained presupposes that the international community has the ability and commitment to do so. Sadly, the evidence to support this supposition seems lacking, and the enormous body of literature available since 1996, including documents from WHO itself, appear to support this observation.

Justice and Ethics as Applied to EIDs

There is also an emerging body of literature which examines the moral and philosophical aspects of globalization and its particular effects on international public health. Perhaps one of the most intriguing approaches to this subject has been provided us by the philosopher, Professor Dale Jamieson,[10] in his treatise "Global Responsibilities: Justice and Ethics in the Era of Global Public Health". One of the many examples of ethical dilemma which he cites for us addresses the paradox of there being currently 270 million people in the world today suffering from malaria. Due to global warming and the resultant increase in spread of the malarial parasite, another 620 million could easily become affected over a relatively short period of time. What are the moral obligations of those who have the power and authority to mitigate or prevent such global warming? What are the moral obligations of those who choose to use their economic, political and/or legal resources for other purposes, e.g. greater profit attainment? What are the moral obligations of those not directly affected by global warming, but who indirectly have the power and/or resources to be instrumental in its abatement? And I would add to this list, what is the moral imperative of the Church and its healthcare leadership to join in active defense against the proliferation of illness and disease.

Organizational and corporate ethics must also be examined in a discussion such as we are having here today. As Pfizer Pharmaceuticals donates millions of doses of their antibiotic Zithromax in an effort to treat various forms of disease in Africa and Asia, they do so with trepidation. Zithromax is one of the most successful and popular antibiotics of our times, and its sales generate an income in excess of $1 billion a year for Pfizer. Their fear is that these drugs donated to Africa and Asia will find their way back to first world countries through the channels of the black market and will significantly undermine their sales in these countries where a five day supply of tablets can cost well over $50. One can well understand their position. On the other hand, can they refrain from assisting with the global crisis of EIDs because of this? The 1994 Treaty on Trade-Related Aspects of Intellectual Property Rights was written with the intent of controlling the practice of producing look-alike drugs, circumventing patent protections. As recently as May 2000, the Office of the President of the United States issued a statement indicating that it would no longer oppose African nations that violate American patent laws in order to obtain AIDS drugs. The Secretary of the Department of Health and Human Services in the United States, Donna Shalala, referred to this position as a delicate "balancing act" between intellectual property rights and the human rights of peoples in third world countries.[11] It is interesting to note that two days after the President's proclamation, five of the largest pharmaceutical companies announced their voluntary willingness to cut prices of their AIDS drugs sold to Africa – including their anti-retroviral cocktails – by as much as 80%. The quid-pro-quo which these companies may

insist on is a commitment from the African countries that they will not proceed to violate American patent rights in the production of these medications.

Any discussion of ethics and justice must focus not only on a national and international perspective, but be inclusive of individual responsibilities and behaviors. It cannot be overlooked that changes in individual behaviors during the past decades have also greatly contributed to the EIDs problem. During the last 20 to 30 years we have seen a proliferation of sexual behavior, often referred to as the "sexual revolution" where multiple partner sexual unions and same sex unions have resulted in an explosion of the transmission of sexual diseases. Poor personal and community hygiene, the use of illicit drugs, overcrowding in family residences, and even, I would argue, the lack of responsibility for one's own health and well being in the areas of adhering to proper diets, medication regimes and balanced life styles, have all contributed to the emergence and re-emergence of infectious diseases and illness.

There is yet another facet of looking at the inter-relationships of emerging infectious diseases and social justice, and that is the debate of individual liberty versus the common good of society. If I choose not to have an annual flu shot and am clearly a person of high risk for contracting the flu, am I free to do so if I will also endanger the health of others? My decision not to take a precautionary step may endanger the health of others who, given the opportunity, would willingly want to be protected from infection. Is there a moral imperative to take public health precautions not only for yourself, but for the good of your family and community as well? There are those who would argue in the affirmative.[12]

Summary Conclusions

Health is a fundamental good which each human has a right to expect and a personal duty to protect and nurture. The rights and duties associated with health are both individual as well as social and common, and must be considered in both the singular as well as social context. The decisions which individuals, communities, corporations and nations make have both direct and indirect effects on the overall common good of our global society. The U. S. Bishops' pastoral on the economy very precisely states that:

"Nearly half a billion are chronically hungry, despite abundant harvest world-wide. Fifteen out of every 100 children born in third world countries die before the age of five, and millions of the survivors are physically or mentally stunted. And their misery is not the inevitable result of the march of history or of the intrinsic nature of their cultures, but of human decisions and human institutions."[13]

In summary, all the above factors, the emergence of new bacterial and viral strains, the mutation of existing strains into drug resistant species, climatic and environmental changes, global overcrowding and poor sanitation, the inappropriate usage of antibiotics in livestock and the misusage of antibiotics in both first world and third world countries, the increased transmission of pathogenic microbes because of globalization and increased international trade, travel and production, the changes in personal and societal behaviors and the public policy decisions of nations and corporations, all contribute to our global inability to control the rampant evolution and spread of diseases, a phenomenon which we today refer to as EIDs or "emerging infectious diseases".

The literature flows with data suggesting that EIDs represent an international public health crisis of daunting and grim proportions. Clearly the international community must rise to recognition that the globalization of public health has presented us with challenges of enormous size and complexity. The World Health Organization and the Church are leading forces in the international community, and is sounding the alarm about this crisis, and we as Church, one of the major purchasers and providers of healthcare throughout the world, must continue to rise and face this issue, and lend our voices and our determinations, with justice and compassion, to the cause of reversing the tidal wave of EIDs.

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Notes

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[3] FIDLER, DAVID P., *The Globalization of Public Health; Emerging Infectious Diseases and International Relations,* Proceedings from the Symposium on The Public's Health in the Global Era; Challenges, Responses and Responsibilities, Harvard Law School, 1997.

[4] TANGLEY, LAURA, *Germs and Sickness in a shrinking World; Are Beasts and Humans Too Close for Comfort?*, U.S. News & World Report May 22, 2000.

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[7] Countryside and Small Stock Journal, *Another Warning on Antibiotic Overuse*, September/October 1998.

[8] World Street Journal, *Merck & Company Will Pledge $100 Million of Vaccines to World's Poorest Children,* Tuesday, March 2, 2000.

[9] JAMES W. LEDUC, *World Health Organization Strategy for Emerging Infectious Diseases*, 275 JAMA, 318, January 24, 1996.

[10] JAMIESON, DALE, *Global Responsibilities: Ethics, Public Health and Global Environmental Change,* 5, Indiana Journal of Global Legal Studies, Vol. 99, No. 118, 1997.

[11] MCNEIL, DONALD G., *Do the Poor Have a Right to Cheap Medicine*?, The New York Times, June 25, 2000.

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Section II
The Illumination of this Reality

ANGELO BRUSCO

I: Theology and Medicine

In the opinion of a well-known theologian, the believer must draw near to reality having open before his eyes, on the one hand, a newspaper, and on the other, the Bible. This theologian wanted to emphasise that in order to acquire an adequate understanding of the questions and issues with which man is faced one should not only know the Word of God but also the situations to which this Word is addressed. If this twofold reading is not engaged in, one runs the risk either of falling into an abstract theology which is addressed to a culture which does not exist or no longer exists, or to confine oneself to engaging in what is mere sociology.

The application of the suggestion made by that theologian seems to me rather appropriate in tackling the subject of the relationship between theology and medicine. Indeed, this is a subject which involves both theological doctrine and the development and evolution of the art of medicine during the course of its history.

In proposing a number of elements of theological reflection regarding the subject of medicine, I will fix my attention on the Bible, without, however, ignoring what is written in the newspaper.[1]

1. Theological Reflection

To reflect in a theological way on the subject of medicine means, on the one hand, to become aware that words of God have already been pronounced on the science and art of medicine, and, on the other hand, to reinterpret the Word of God in the light of medicine itself. This is because the God of the Creation and of redemption is constantly active in the heart of the experience of man. The Word of God in relation to the health care professions has been revealed in a special way through Holy Scripture. Down the centuries it has been interpreted in an authoritative way by the Magisterium of the Church; theologians have made it the subject of their reflection and thought; and it has found expression in the *sensus fidelium* and in the witness of a very large number of workers in the world of health. Outside the context of Christian revelation and the Christian denominations there are also numerous traces of the vision of God in relation to that activity of man which is directed towards caring for, and treating, the sick person.

Three guidelines for the behaviour and conduct of people who are engaged in the practice of medicine emerge from theological reflection.

2. The Word of God and Medicine

A large number of guidelines emerge from what is said about medicine in the Bible and in other sources (the Magisterium, theology, etc.). In this paper only some of these guidelines will be examined and discussed. First of all, the greatness and the limits of man and medicine will be analysed. Then the affective dimension of caring for and treating the sick person will be investigated. And lastly, attention will be paid to the promotion of health.

2.1. The Greatness and Limits of Man and Medicine

During its history, medicine has always enjoyed great prestige. Because of its links with life and health it has often been endowed with an aura of sacredness. Even those literary or audio-visual works which have employed satire to bring out the negative aspects of medicine have stressed its pre-eminent role in the life of individuals and societies.

In the Bible[2] we encounter a limpid echo of this positive view of the art of medicine which is presented as co-operation between the creative and redemptive work of the Lord. The person who is involved in taking care of sick people, in fact, strives to respond to the groans of the Creation to which St. Paul referred (Rom 8:10), thereby writing his action into an eschatological dimension in the search for new heavens and a new earth (cf. 1 Pt) which are the aspiration of every individual and of mankind.

In a frequent and fulsome way the documents of the Church emphasise and outline this vision of medicine, reacting with joy to the great advances achieved by medical science and technology. In the introduction to the rite of the anointing of the sick one thus reads: 'the Church encourages and blesses all research and every initiative undertaken to defeat infirmity because she sees in them a collaboration of man with the divine action of struggle against, and victory over, evil'(n. 134).

At the same time, however, these documents do not hesitate to con-

demn the deviant aspects and features of the practice of medicine. In the first place, they condemn a *Promethean* tendency which leads large sectors of the science and art of medicine to ignore the inherent limitations to the human condition.[3] The development of increasingly powerful means and instruments, in fact, helps to cultivate and to make increasingly explicit that wish which slumbers in the unconscious of man – to be invulnerable and eternal. Cloning, for example, can be seen as one of the expressions of the mythical desire for immortality. If it is possible to be cloned when we become old is this not a way of

escaping death, a way of being eternally reborn? Secondly, they condemn the move of the subjects of health, suffering, and death away from the terrain of meaning and value to that of what is technical.[5] With much precision Buytendinck observes that: 'the enormous possibilities of medicine have removed the problem of pain... from the metaphysical, moral and religious sphere and have transferred it to the practical sphere'.[6] At the existential level, this detachment of medicine from its mission as a collaborator of the creation and redemption strengthens the tendency to want to achieve human destiny without reference to the design of God for humanity.[7] But it does not do only this. It also opens up the road to a 'generalised algophobia', that is to say to horror of suffering, to obsessive worry and concern – which, indeed, is almost pathological in character – about health, and to a narcissistic approach which is derived from an excessive attention and care being directed towards one's own body.[8]

The rejection of the finite condition of man is not without its repercussions at the psychological and spiritual level. Indeed, the drama of the clash between limitless technical advance on the one hand, and the inescapability of death on the other, has a negative effect on research into the meaning of life, and on the drawing up of a scale of values which respects the human person and nature. This does not fail to cause existential dramas and noological neuroses that are at the root of so many disturbances.[9]

The help offered by the Word of God and theological anthropology in order to escape this drama involves first of all the affirming of the greatness and beauty of the human being. An ephemeral creature destined for immortality, limited in space and time and at the same time thirsty for the infinite, an animal and an angel, as Pascal says, man does not stop provoking exclamations of amazement on the part of the Psalmist: 'When I look at thy heavens, the work of thy fingers, the moon and the stars which thou hast established; what is man that thou art mindful of hum, and the son of man that thou dost care for him? Yet thou hast made him little less than God, and crown him with glory and honour. Thou hast given him dominion over the works of thy hands; thou hast put all things under his feet, all sheep and oxen, and also the beasts of the field, the birds of the air, and the fish of the sea, whatever passes along the paths of the sea. O Lord, our Lord, how majestic is thy name in all the earth!' (Psalms, 8:4-9).

Medicine is called upon to strive to defend the integrity of the human being, as was well expressed by John Paul II when he addressed a gathering of medical doctors: 'I encourage you to continue your research fervently, to care for and treat with the greatest skill, to fight illness in all its forms and the natural and human causes which bring it about. All this is a part of the plan of God who gave man the intelligence and ability to advance his discoveries connected with the human organism and to place its fruits at the service of man'.[10] To a recognition and defence of the greatness of man, medicine must, however, add an attempt to accept and respect his 'creatural weakness which does not wound his ontological dignity but endows his corporeal impediment with mysterious meaning by pushing beyond our gaze'.[11] Indeed, as Pius XII observed: 'the Catholic physician knows that his patient and he himself are subjected to the law of conscience and the will of God. But he also knows that all the resources of nature are placed at his disposal to protect and defend men from illness and infirmity. He does not make nature or medicine divine, he does not see them as absolutes, but he sees in them a reflection of the greatness and the goodness of God and perceives that they are entirely subordinated to his service'.[12]

2.2. Vulnerability, Human and Spiritual Growth, and Healing

In addition to being a guideline in relation to the limits of the human condition, in the light of theological reflection human vulnerability, when taken on and assimilated, can also be transformed into an instrument of healing and human and spiritual growth for oneself and for other people.[13] Indeed, as Carl Jung observed: 'only the wounded physician can heal'.[14] That is to say, the medical doctor who is able to welcome and assimilate his own wounds.

This belief, which is rooted in the culture of past and present mankind, finds an admirable expression in the Bible. After describing a day spent by the Lord in serving sick and infirm people, Matthew (cf. 8: 16-17) quotes some of the words of the prophet Isaiah (52:13; 53:12) and applies them to Christ: 'Surely he has borne our griefs and carried away our sorrows; yet we esteemed his stricken, smitten by God and afflicted. But he was wounded for our transgressions, he was bruised for our inequities, upon him was the chastisement which made us whole, *and with his stripes we were healed*' (Is 53:4-5). The suffering of Christ has a power of healing and salvation because it is the sign of that mysterious *movement* which led the Son of God to share the human condition in all its aspects and features, even in its *dimension of night time*, made up of physical and spiritual trials. St. Paul described this process in a wonderful way in his letter to the Philippians: 'His nature is, from the first, divine, and yet he did not see,

in the rank of Godhead, a prize to be coveted; he dispossesed himself... accepted an obedience which brought him to death, and death on the cross'(Phil 2:6-9). It is this interior *movement*, given substance by love, which makes Christ the *physician par excellence of souls and bodies*. He 'suffered our darkest nights: corporeal death and the night of faith. Nothing which happens to man will be extraneous to his creator. Jesus took on the full non-sense of suffering and death'.[15]

Although he struggles constantly against suffering and death, the medical doctor is, therefore, also called upon to reconcile himself with the *nocturnal dimension of life*, which, despite scientific and medical progress, will always form a part of human existence.

What are the wounds of the medical doctor? Sharing human destiny is the first door through which factors burst forth which lacerate the human person in all his dimensions. The health care worker, like every individual, must deal with the suffering linked to loneliness, illness, growth, separations, physical and emotional loss, existential emptiness, immaturity, and sin... In addition to these wounds there are others connected with his profession: daily contact with pain, death, crisis situations, and spiritual debate and discussion with individuals. There is a kind of process by which the wounds of the sick person, the tensions of the client, the desperation of the family relatives, all become thrown, after a certain fashion, onto health care workers.

Turning to more specific aspects, Sgreccia[16] stresses certain factors which disturb the ethical-professional identity of the medical doctor and cause disturbance and suffering. For many health care workers there is in the first instance 'the abandonment, effected by law, of the defence of the value of life'. Born to serve life, the medical profession 'is requested and required' to eliminate it. Secondly, there is the social organisation of health care which 'places the medical doctor in front of depersonalising situations or situations of a company or bureaucratic character which are alien to the traditions of his profession'. A third 'factor which endangers or reduces dialogue, communication, and a direct relationship between the medical doctor and his patient, is technological progress and the consequent increasing use of machines and laboratory tests to carry out a diagnosis'.

In addition, how can one forget the wound created by the *feeling of powerlessness* which is experienced in the face of situations which are beyond the medical doctor's possibilities to engage in effective action? It is not easy to recognise one's own limitations, an inability to save a life, to help a sick person overcome impulses to depression, or to accompany a person in the taking of a decision at dramatic moments of his existence. The feeling of powerlessness wounds human narcissism, that idea of being all-powerful in solving the problems connected with the destiny of man.[17]

When the medical doctor is not aware of, denies or rejects his own

wounds he can have a number of different reactions. One author lists among these that of flight, that is to say not wanting to engage in dialogue with the sick person or the dying patient, giving him only a technical or impersonal form of treatment, or a disproportionate and obstinate assault through drugs or surgery which constitutes a kind of titanic struggle against realities which are rejected and perceived as a threat not only to the patient but to the deep and unconscious self of the medical doctor himself.[18]

When there is an aspiration to invulnerability or a denial of the hard and painful realities of life and one's own limitations, there is little space for compassion and a lack of a recognition of the freedom of the patients and their ability to take part in the process of healing. As Nouwen observes on this point: 'the person who in his own life is always protected against experiences of pain will be able to offer only empty consolation to other people'.[19]

To create peace and a synthesis within oneself with *the nocturnal dimension* of life – suffering, illness, death, immaturity, and sin – is a difficult process. But it is a liberating experience which leads the individual to overcome the illusion of being an invulnerable and immortal being. His suffering reveals to him the thin boundaries which separate life from death, health from illness, and good from evil. It also helps him to discover the value of existence which is brought out by his own fragility. Of illumination here is the episode of the struggle between the angel and Jacob which is narrated in chapter XXIII of the Book of Genesis. Returning from Palestine after a long absence, Jacob crosses the Yaboc brook, a tributary of the River Jordan. He sends his caravan on ahead and remains on his own on the bank of the brook. Towards the end of the night he engages in a struggle with a mysterious figure. This figure is unable to defeat Jacob and so hits him on his sciatic nerve, something which leaves him with a limp. The mysterious figure, when the night is about to come to an end, asks Jacob to let him go but this latter refuses unless the mysterious figure gives him his blessing.

The most evocative symbolism of this episode is that of the struggle of the people of Israel with the mystery of God, especially his way of acting in relation to human suffering. Why does pain exist? How can it be reconciled with the omnipotence and goodness of the Lord? This struggle takes place in the full night of mystery and lasts as long as the night. Pain is connected with the darkness of the night which is not seen as a negative value but as a mystery, to which only God knows the answer. The night is the moment when God condenses to the highest degree his mysterious action. But every night is followed by dawn...[20]

The dawn of the Old Testament proclaims the day of redemption effected by Christ. Although it does not lose its mysterious character, the suffering of man acquires meaning when it is 'closely connected with the suffering of God himself'. In other words, what man suffers, whether of an intense or minor na-

ture, is an experience which, far from being isolated, is connected with the very suffering of God. With great exactness Nouwen observes that Christ heals our pain by removing it from our egocentric, individualistic and private context and connecting it with the pain of the whole of mankind which he takes upon himself. In this sense 'to care for and treat does not, therefore, mean above all else to eliminate pain but to reveal that our pain forms a part of a greater suffering, that our experience is a part of the experience of he who said: 'Did not Christ have to undergo this suffering so as to enter into his glory?'(Lk 24:26).[21]

The efforts of medicine to combat illness, with the risks that accompany such efforts of making medicine fall victim to unrealistic aspirations, is a stimulus in favour of a re-reading of the Word pronounced by God on human pain. One of the guidelines which emerges from this re-reading leads to an emphasis on the need to overcome 'painism', that is to say an attitude involving 'interpreting pain as an element in itself of value, at times even exalting it, or in extreme case even searching it out'.[22] As Enzo Bianchi correctly observes: 'Jesus opposes evil and tries to liberate man, who is its victim, from it. Jesus never preaches resignation, he never displays a search for suffering for its own sake, he never advises 'painist' approaches. Instead, he involves himself in a struggle against evil and illnesses, responding to numerous supplications for recovery that the many miserable people who draw near to him direct towards him'.[23]

2.3. The Emotional Dimension of the Exercise of the Health Care Profession

The acceptance and assimilation of one's own wounds, which are linked to the limited human condition, not only makes us able to listen to the message which comes from suffering. It also enables the health care worker to draw near to those people who suffer in a way which displays greater humanity.

One of the subjects which has been debated during our time has been that of the humanisation of service to the sick. This neologism refers to the need to adapt as much as possible the *being* of care for, and treatment of, the infirm, to its *having to be*. In this debate, the relationship between health care workers and the sick occupies an important position.

The person who suffers lives out the experience of a laceration of the body and the spirit. His suffering, which is expressed in pain, illness and death, is a sign, a 'coded message', a cry which speaks to the human person. The sick person needs his appeal, which speaks of human finiteness and the mortal condition of the individual, to be listened to; the emotions which accompany him – anxiety, fear, and hope – should be taken notice of. The cry of the sick person is not suitably understood in a society that tends to treat suffering in a merely technical way, that is to say by trying to eliminate it before trying to understand its meaning. Removed from the consciousness in which it is experienced, suffering is reduced to a mere symptom, and it is thereby alienated and dehumanised. In this case it is suffering rather than the person which is the subject of care and treatment.

Although pain is fought and combated with medical means it is important to understand that it is a sign for the conscience. In this way the monopoly of technical action is broken and pain can to a certain extent speak about and transmit its meaning because it is a cry of meaning. There can be no doubt that 'health treatments' of every kind have multiplied in number and that maladies are fought and combated with great force. But will all this be enough to meet the expectations of the sick person? Does he not often feel, even amidst all these forms of treatment, harshly returned to his loneliness, not understood in relation to his requests, because he has become a thing, a consumer without a voice? Listening to the song that the patient sings is made difficult by a number of factors. Professional training, the organisation of work, and professional or corporate interests, all have the effect of leading those responsible for care and treatment to engage in technical tasks more than other kinds of task. They must react strongly in order to avoid fleeing from the sick person. This is even more the case given that they are tempted to protect themselves against the image of themselves which is reflected in the faces of their fellows, afflicted, as they are, by suffering.[24]

This relational disturbance, which reflects a general tendency and not necessarily the behaviour of individual health care workers, is encouraged by the tendency to reduce service to a mere function. From this point of view, the other person is not seen as a person but only as somebody who gives or receives services. Attachment, interest, and love tend to be replaced by the rules of the contract of work. There is a lack of passion and compassion,[25] that is to say that 'intimate emotion – deep identification with those who suffer or who are in need – which is the beginning of every real form of moral responsibility and thus of responsibility in the field of health and health care'.[26] In fact, as the psychoanalyst Fran-Hoise Dolto well observes: it is 'the emotion of compassion which engenders inter-psychic communication between people; there is care for the body which requires skill and which is paid for, and there is the emotion which makes us human. When this is absent it is because service has become an institution, or because the encounter is not unique but has become a *remunerative* work or an occupation without passion. The person who is treated in this case is nothing else but an object. A human relation no longer exists'.[27]

In the face of this phenomenon, which expresses itself in a variety of forms, theological reflection invites us to turn our gaze to Christ, the divine Samaritan of souls and bodies. This title captures all the work carried out by Jesus in favour of the sick – 'moved by compassion he drew near...' About a third of the Gospels deals with the healings carried out by Christ and has observations made at the time of these healings. 'Of the 3,779 verses of the Gospels, 727 specifically refer to the healing of physical and mental illnesses and to the resurrection of the dead. In addition, we find 32 general references to miracles which involve healings'.[28] From all these texts it is clear that the taking

part of Christ in human destiny is not neutral but full of a strong affective intensity. In the Gospels the verb *splanechnizomai* is used twelve times to describe the approach adopted by Christ. The meaning is the following: 'to feel something in one's own guts'. In his contacts with people who suffer and are in need Jesus reacts with emotions: he strongly feels their suffering to the point of being moved in his whole person by them and to weep at them, as happened to him in the company of the widow Naim and at the tomb of Lazarus. The emotion of Jesus, which is expressed in concern and compassion, is already a source of healing. In *Salvifici Doloris* John Paul emphasises this concept and states that the readiness to help expressed by the Samaritan towards the wounded man was accompanied by an expression of emotion: 'If Christ, who knew man from within, emphasises this emotion this means that it is important for the whole of our approach to the suffering of others. One should, therefore, cultivate within oneself this sensitivity of the heart which bears witness to *compassion* towards a suffering person. At times this compassion is the only or principal expression of our love and solidarity with a suffering man'(n. 28).[29]

Through his way of acting on behalf of sick and infirm people, Jesus demonstrated with clarity that union with God 'is obtained and maintained through compassion towards others and in particular torwards the sick'.[30] Breaking the traditions of the time in which he lived, Jesus drew near to lepers, who were considered impure and contagious, placed his hands on many sick people, and commanded his apostles to do likewise (cf. Mt 9:25; 10: 7-8).

The example of Christ had a decisive influence on the ethos of medicine at the dawn of the Christian era, inserting within that ethos the elements of philanthropy, charity, and compassion. In fact, in pre-Christian medicine 'even when the ethical model of virtue derived from the ideal of philanthropy reached its highest maturation and expression one observes that there is a notable distance and coldness in the relationship between the physician and his patient'.[31] The exclusion of providing health care was applied to incurably ill people and to those who were dying.

Since the beginnings of Christianity the cardinal elements upon which theological reflection on compassion as a element in the practice of medicine has been based are the incarnation of Christ and the idea that man is *imago Dei*, the image of God. On the basis of these truths, the Christian community has directed its therapeutic activity to every category of suffering people, whether believers or not, and has managed to transform service to the sick into a mediation of divine tenderness and compassion, and into an authentic experience of the Lord – 'I was sick and you visited me'.

The impulse to insert compassion into the practice of medicine entered into the health care philosophy of the West and transformed the health care act not only into *treating* but also into *taking care of*, something which implies a *personal involvement* of the health care worker with the person who is suffering – an involvement expressed through compassion, concern, encouragement and support.

With the advent of scientific medicine, treatment of the sick person has become increasingly entrusted to technology, and at the same time care for the sick person in his totality has grown weaker. In the opinion of a historian of medicine: 'an unintentional but inevitable result of the secularisation of health care institutions has been to separate them from the source which gives rise to compassion. It is no accident that compassion, leaving aside obvious individual expressions, is absent from modern medicine'. And yet, this authority continues: 'compassion is a quality which is fully compatible with scientific medicine and the advance of technology. But it does not come from them. Compassion is the wish to treat the sick person not only in a competent and professional medical way but also to treat him with love and tenderness because he is a human being worthy of being attributed great love, and who bears the image of God. Compassion can be wished for, encouraged, and cultivated. But without a transcendental and spiritual base it is destined to dry up and to die in a rocky soil which offers no sustenance'.[32]

In the light of the observations made above one can more effectively understand and appreciate – from a Christian anthropological point of view as well – the move from *treating* (which involves the elimination of the illness) to *taking care of*.[33] In the concept of *taking care of* are to be found both professional competence and scientific training, and the personal involvement which leads us to concentrate on the person of the patient, whose experiences, even though they cannot be penetrated by us to the full, can, however, move us deeply. This is because we share the same humanity as the patient. To paraphrase Kant, we can say that if professional competence without the moral quality of life is empty, for its part incompetent treatment is blind. To take care of the patient is then a *synthetic* act in which intelligence no less than the heart has its role and its place.[34]

In a significant book which was written in the early 1980s (entitled *In a Different Voice*),[35] the American Carol Gilligan expresses the need for such a synthesis in a very significant way. The *different voice* that the author talks about involves (in the world of health and health care) drawing near to people with an approach of participation rather than one of detachment, of agreement and compassion rather than abstract rationality. This is a voice which emphasises the primary importance of the person, his singularity, because he asks to be taken into consideration for his own sake. This is a voice which down the centuries has been largely expressed by women, but which does not belong to women alone, even though our tradition has confined it to them.[36]

In moving from *treating* to *taking care of* professional behaviour based only on the rights of the sick person and the duties of those who treat him becomes overcome. One reaches, that is to say, an experience of what it means to decide to listen to the appeal which comes from the special condition which is being lived out by the person who is in a situation of illness. In answering this appeal, therefore, one engages in more than the mere performance of one's 'duty'. In the concrete real-

ity of a precise human relationship there is not only brought into play the rules which structure the health care profession; at a deeper level one gives form to the specific moral identity of people.[37] The experience of the health care professional makes the epiphany of otherness possible, that epiphany of otherness to which Levinas refers and which makes the essence of moral experience an experience of encounter with another person, with the *face* of another person.[38] That *face*, for believers, has the features of Christ.

In order to achieve this objective we need to enter into harmony with the sick person and his family relatives through that approach which is called empathetic listening. The

new medicine – which is similar in this respect to the good medicine of yesterday and of any time – begins with a listening which enables us to establish who the person is who must be treated, what his moral world is, how the search for his happiness should be organised, what his preferences are, and what a good life and a good death are for this individual.

During his experience of infirmity, the sick person is placed in the hands of health professionals so that they *can take care of him*, that is to say so that they can help him to keep himself whole, to reacquire his lost humanity, 'to reconnect his infirmity to the story of feelings it generates in the lived experience of the person', to escape his loneliness, to find a meaning... beginning with the knowledge that what wounds the body of an individual equally wounds his soul at a deep level.

The activity of the health care workers is thus written into human activity in general, thus becoming one of its most meaningful expressions. Animated by faith, it reproduces in an effective way the behaviour and conduct of the Good Samaritan.[39]

The situation of disturbance produced in the context of the health care world by the difficulty of harmonising *treating* with *taking care of* is an invitation to investigate from a theological point of view the importance of affective involvement, and in particular to give greater value to the feminine dimension of society in general and the world of health and health care in particular. Here the *Mulieris Dignitatem* of John Paul II offers important guidelines for reflection. 'The moral strength of women', observes the Pope, 'their spiritual strength derives from the awareness that God entrusts man, the human being, to her in a particular way. Naturally, God entrusts man to everybody and everyone. However, this entrusting refers above all else to women specifically because of their femininity'. Later on he adds: 'In our epoch the successes of science and technology allow us to achieve in ways which are still unknown a material well-being which, while favouring others leads others to marginalisation. This material progress can also lead to a gradual disappearance of the sensitivity of man towards what is essentially human. In this sense, our time expects above all that manifestation of the *genius* of women which ensures sensitivity towards man in every circumstance because of the simple fact that he is a man!'(n. 30).

If what the Pope maintains is valid for every context, this is especially the case in relation to the world of health where man, in experiencing the fragility of his own existence, can easily fall victim to indifference and violence. A more active and co-responsible participation of women in the mission of the Church in the health care world would lead to significant changes in the approach to people and problems in the world of health. Would it not be a good thing to see the presence and the action of the Church, its language, its theology, its perception of reality and of God, further enriched by those characteristics which are typical of the feminine personality: receptivity, readiness to help, welcome, a capacity to listen, the ability to understand situations, the capacity to take on the problems of other people, and the inclination to offer their help? Proposing the institution of 'a ministry of the pastoral care of the sick', Melitello believes that women above all should be active in it: 'because of their closeness to the mystery of life which is born or life which passes away'. Indeed, 'the closeness of women to the strong moments of life is more felt than is the case with men'.[40]

2.4. Which Health?

Scientific and technological advance and socio-cultural evolution have opened up new paths for medicine. 'If, indeed, until yesterday there was only a *medicine of needs* (which was practiced through the triad of prevention-treatment-rehabilitation), today there also exists a *medicine of wishes*, whose social incidence is no less marked. In addition, if yesterday's medicine could at the most restore the human organism to its previous completeness, today it is able to improve it, to alter it, even to manipulate its genetic arrangements. Moreover, if until yesterday the primary objective of medicine was to *make people live*, today there is also the goal of *making people live well*, something which involves not only the quantity of life but also the quality of life'.[41] We are face to face with a new concept of health according to which it is no longer sufficient to fall ill and then get better, but it is necessary to strive for 'a *fullness* in which not only our primary needs are satisfied, but also those which we could define as secondary because they are subordinate, thereby imperceptibly entering into the realm of wishes'.[42]

The panorama of the new directions of medicine is very wide. One need only think of the medicine of reproduction, of aesthetic medicine, of the medicine of sport, of genetic engineering which aims at improvements, at forms of treatment directed towards the body...

The increase in the kinds of application of medicine and the re-

sults to which it gives rise undoubtedly produce positive results. Indeed, as Leone Salvino rightly observes: 'well-being and quality of life cannot but refer to that existential fullness and that qualitative absoluteness which characterise the eschatological dimension of existence'.[43] However, they also give rise to negative consequences, such as a weakening of respect for life and a reductive concept of health. Indeed, while major and intense efforts are made to prolong life or create it artificially, the person who has already been conceived is not allowed to be born and there is a tendency to marginalise those who are

not believed to be useful – the handicapped, the dying, the elderly... Furthermore, although on the one hand health is rightly endowed with value and there are efforts to increase the ways of promoting it, on the other hand it becomes an absolute value of consumption and it is reduced to its mere biological dimension or to vitality and is in large measure associated with beauty and youth.[44]

In the face of these negative developments a whole host of questions arise: how can we harmonise, in caring for and treating the person and his growth, technical logic and ethical logic, scientific-technical advance, and the order of values and ends?[45] Is it possible to have a form of medicine which is concerned with the person in the totality of his bio-psychic-spiritual being? How should we assess all those movements which use spirituality and religion as therapeutic factors, capable that is to say of promoting healing and the achievement of the full well-being of the person?

In considering these question, which are increasingly frequent in our society, theological reflection begins with Christ. Jesus, in carrying out his mission, also aims at the *fullness* of the life of man: 'I have come so that they may have life; and have it more abundantly' (Jn 10:10). It is true that the salvation brought by him has the aim of raising man to taking part in divine life along a path of alliance through a relationship which leads us to move out of ourselves and assume our responsibilities in the world. This, however, does not mean that this is a disembodied salvation, something which is not called forth by joyous experience of living and of living to the full. 'The experience of faith, in fact, involves the whole of the human person, in his unity of body and spirit. The whole of Biblical revelation bears witness to the fact that every experience of God is an experience of life, of liberation from every form of slavery to evil and the promotion and raising of life to the point of taking part in the fullness of divine life.'[46] Maggioni observes: 'The salvation of Jesus always reaches the deepest part and touches man at his centre. To redirect man in his relationship with God, Jesus worked through the body – he healed. But he did not confine himself to helping bodies – he liberated man from sin and not only from illness, loneliness and non-sense, not only from need.'[47] From an evangelical perspective, therefore, the promotion of psycho-physical health and well-being can become signs of the Kingdom installed by Christ, openness to the welcoming of salvation, indicators of a condition which will find its full realisation during the eschatological era.

Bringing about everything that is legitimate to ensure increasingly better conditions of life for all human beings is, therefore, a part of the divine plan. This endeavour, which bears upon the responsibility of man, must in the first place seek to achieve the growth of the human person at the level of all his dimensions, opening him as well to that call to transcendence which is written into every human being. In this approach health involves 'the best harmony possible between the forces and the energies of man, the most advanced spiritualisation possible of his corporeal aspects, and the most beautiful corporeal expression possible of the spiritual. True health manifests itself as the self-realisation of the person achieved by that freedom which mobilises all his energies for the fulfilling of his overall human vocation'.[48] It is also the case that the overall and holistic approach present in taking care of and treating the sick person and in programmes for the growth of the human person – an approach which is today being constantly examined in the world of health and in society in general – finds an impulse to becoming more complete in the teachings of Christ. This is not a matter of only becoming aware of the different dimensions of the person but of knowing how to relate them in terms of a scale of values which is increasingly rich. This scale of values, which finds its highest expression in the teaching of the Gospel, helps us to make choices and also to make those sacrifices by which to respect life, and to defend the dignity of one's own person and that of other people, in order to maintain vital the tendency towards the transcendent.

Secondly, the action of accompanying the person towards well-being must be guided by an awareness that the goal of human life is to be located well beyond the immediateness of perfect well-being, even through the human being is destined to know happiness from that moment. This is a question above all else of entering into friendship with God, of being received by his tenderness in trust, even when we are faced with the limits which are inherent in the human condition, something which is very visible when *the body falls into disrepair*. Despite the limits of illness or handicap the human being can fulfil himself and acquire that beauty that remains such even when it does not correspond to the cultural parameters which exist. It is in this sense that St. Augustine refers to the beauty of Christ who was resplendent not only in the happy and exalting moments of his life but also during those moments on the cross.[49] If, indeed, the salvation achieved by Christ is a source of

health, it is such in the dynamics of his paschal mystery, his death, and his resurrection. This involves a necessary moderation of desires, an overcoming of selfishness in order to achieve a better distribution of resources, agreement with reality, that indispensable condition for authentic growth. 'This approach of agreement with reality is not exclusively Christian, given that it is already present in most of the systems of wisdom in the world. The difference lies in the fact that for the Christian this path reaches a culminating point in profound adherence to a filial approach' in relation to the Lord. 'Then divine grace – the freely-given love of God – can collaborate fully with a profoundly respected human freedom in a relationship of otherness... It is then that salvation is received to the full, even though healing is not perceivable from the medical point of view'.[50] Acting outside this approach one runs the risk of transforming faith into a *medical service*, or into a ingredient which can only bestow greater serenity on the person, or into a good relationship with oneself. In this case one runs the risk of exploiting faith in order to achieve the psycho-physical well-being of the human person, deceiving him in relation to his wish for invulnerability and immortality.[51]

To bring out the salvation he effected, Christ worked miraculous healings which were signs of the transformation achieved in the innermost part of the human being. Today, as well, signs are needed, probably not along the lines of the miracles performed by Christ, but in the spirit in which he brought them about – love. 'Faith and love can really heal, in relation to the extent to which they restore the unity of the person, without this involving necessarily physical or mental healing... Community is the sacrament *par excellence* of healing'.[52]

The context in which contemporary medicine finds itself and its commitment to improving the human condition through the promotion of a growing fullness of life is an invitation.[53] 'An act of salvation can only take place with a body, in a body, and not against a body, even though this involves progressive liberation, or an assimilation of its dark burdens, its violence and narcissism, of the thirst to possess'.[54] Furthermore, perhaps the time has come to 'return to the analysis of the relationship which theology discerns between *responsibility* and *hope* within the believer, also understood as a commitment to perceiving the cause of the malady, promoting a lifestyle which fosters the psycho-physical and spiritual well-being on the one hand and an approach of trusting in, and entrusting oneself to, God, on the other.[55]

Conclusion: the Lessons of Witnesses

Between medicine and theology a fertile relationship can be established. History bears witness to acts of drawing near and to fractures. From the literature on the subject, which is at an advanced stage although not yet systematically worked out, comforting results may be expected. Positive results have arrived and continue to arrive from the witness of very large numbers of health care workers – medical doctors, nurses, and so forth – who have lived out their profession with a mission directed both towards healing the wounds of sick people and promoting human health in the light of the principles of the Gospel. Their practical teaching has helped, and continues to help, to deepen the intelligence of faith of the health care profession. Some of these have been proposed as models for the veneration of the People of God; others have followed the divine Samaritan of souls and bodies without having been explicitly aware of the fact. In *Salvifici Doloris* (nn. 28-30) John Paul II recognises the value and strength of such witness. Uniting skill with compassion, and being able to see the face of Christ in the sick person, they have made of their health profession an expression of the charity of God and an authentic realisation of the Christian vocation, thereby also demonstrating that man created in the image of God, of a God who is love, can only be authentically fulfilled in love.

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Notes

[1] What is said in this paper in relation to medicine also refers to the world of health care and health in general.

[2] Cf. P. GUAER, *Le Christ Médicin: Soigner, la Découverte d'une Mission à la Lumière di Christ-Médicin* (CLD, Chambrai-lès-Tours, 1994).

[3] Cf. *Evangelium Vitae*, n. 15: 'On a more general level, there exists in contemporary culture a certain Promethean attitude which leads people to think that they can control life and death by taking the decisions about them into their own hands'.

[4] Cf. A. KAHN, *Et l'Homme dans tout ça?* (NIL, Paris, 2000), p. 233.

[5] CF. J.M. VELASCO, 'Mundo de la Salud y la Evengelizaciòn, in AAVV, *Congresso Iglesia y Salud* (Madrid, 1994), pp. 218-219.6. F.J.J. BUYTENDICK, 'El Dolor', in *Revista de Occidente* (Madrid, 1958), pp. 23-24.

[7] A typical example of this orientation is once again the cloning of humans, a paradigmatic subject of this move from one millennium to another. It brings into question the deep anthropological meaning of the way in which a man and woman co-operate in the birth of a new created being.

[8] J.M. VELASCO, *op. cit.*, p. 218.

[9] A. BRUSCO, *Umanità per gli Ospedali* (Salcom, Varese, 1983), p. 23: 'In the world of medicine, more than in other sectors, the contradiction breaks out between the dream of absolute progress and reality. The real of death penetrates the imagination of technological humanism and reveals its illusory character. This is the *modern tragedy* in which the progress of science and technology clash against the powerlessness of the human person in relation to finiteness'.

[10] JEAN PAUL II, 'En Etant les Défenseurs de la Vie vous etes les Coopérateurs de Dieu', *Dolentium Hominum*, 3 (1986), p. 20.

[11] L. SALVINO, *op. cit.*, p. 1097.

[12] PIO XII, 'Radiomessaggio al VII Congresso Internazionale dei Medici Cattolici', in *Pio XII, Discorsi ai Medici*, edited by F. Angelini (Orizzonti Medici, Rome, 1966), p. 504. Cf. L. BUCCI, *Cristo Medico, Implicazioni Etiche di un Motivo di Antropologia Teologica nel Contesto del Dibattito Bioetico Recente* (Camilliane, Turin, 1998).

[13] Cf. A. BRUSCO, 'Vulnerabilità Personale e Servizio a chi Soffre', C*amillianum* 8 (1993), pp. 223-241.

[14] C. JUNG, 'Fundamental Questions of Psychotherapy', in *Collected Works*, vol. XVI (1951), p. 116.

[15] G. CINÀ, 'Il Linguaggio della Sofferenza', *Anime e Corpi*, 165 (1993), p. 78.

[16] E. SGRECCIA, *Pastorale Sanitaria, Istanze Etiche e Culturali* (Salcom, Varese, 1987), p. 207.

[17] Cf. C. NOTATO, 'Il Guaritore Ferito', *Camilliani*, 67 (1993), pp. 311-312.

[18] E. SGRECCIA, *op. cit.*, pp. 203-204.

[19] H. NOUWEN, *Il Guaritore Ferito* (Querini-ana, Brescia, 1982), p. 98.

[20] Cf. J.L. CARAVIAS, *Fe y dolor, Respuestas Biblica ante el Dolor Humano* (Selare, Santafé di Bogotà, 1993), p. 18.

[21] H. NOUWEN, La Memoria Viva de Jesucristo (Guadalupe, Buenos Aires, 1987), p. 23.

[22] L. SALVINO, 'Salute: Approccio Etico e Pastorale', in Dizionario di Teologia Pastorale Sanitaria (Camilliane, Turin, 1997), p. 1096.

[23] E. BIANCHI. 'Preghiera', in Dizionario di Teologia Pastorale Sanitaria (Camilliane, Turin, 1997), p. 931.

[24] Cf. *Salvifici Doloris*, n. 30: 'The Gospel is the negation of passivity in the face of suffering. Christ himself in this field is above all else active'.

[25] J. PROULX, 'Santé, Sense et Salut',

Critière, 14 (June 1976), p. 113. Cf. P. Cattorini, *Malattia e Alleanza* (Florence, 1994), p. 19: 'The interpretation of the medical act to the effect that it is a technical service, an interpretation which corresponds to the reduction of the therapeutic act to a commercial negotiation, to an exterior supply and use of services, almost an action of mechanical repair, has obscured the original dimension and the radical spring of the institution which provides care and treatment – the call for help addressed by a suffering person to another man'.

[26] *Ibid*., p. 18.

[27] F. DOLTO, *L'Evangile au Risque de la Psychanalyse* (Delorge, Paris, 1977), pp. 162-163. 28. C. Vendrame, 'Le Guarigioni dei Malati come Parte Integrante dell'Evangelizzazione', *Carmillianum*, 2 (1991), p. 30.

[29] In the fifth chapter of the encyclical *Evangelium Vitae* the role of compassion in service to life and suffering people is masterfully expounded.

[30] A. VANHOYE, *Vita Consacrata Sanitaria, Fondamenti Biblici* (DTPS), p. 1390.

[31] S. SPINSANTI, *L'Alleanza Terapeutica* (Città Nuova, Rome, 1988), pp. 67-68. Cf. G.B. FERNGREN, 'Medicine and Compassion in Early Christianity', *Theology Digest*, 46, 4 (1999), pp. 315-316.

[32] G.B. FERNGREN, *op. cit.*, p. 324.

[33] Cf. E.D. PELLIGRINO and C.D. THOMASMA, *Medicina per Vocazione* (Dehoniane, Rome, 1995); W.T. REICH, 'Curare e Prendersi Cura. Nuovi Orizzonti dell'Etica Infermiearistica', *L'Arco di Giano* 10 (1996), pp. 11-24; S. SPINSANTI, *Curare e Prendersi Cura* (CIDAS, Rome, 1998).

[34] In the document of the national consultatibe body for pastoral care in health, *La Pastorale della Salute nella Chiesa Italiana*, it is stated that professionals of health are called upon 'to acquire the broadest profesional ability in the belief that honesty and professional competence... can only with difficulty be substituted by another kind of apostolic zeal' (n. 53).

[35] C. GILLIGAN, *In a Different Voice: A Psychological History of Women's Development* (Harvard University Press, Cambridge, Mass., 1982).

[36] Cf. W.E. LECKY, *History of European Morals*, vol. 2, pp. 361-363.

[37] Cf. *ibid.*, p. 12.

[38] Cf. E. LEVINAS, *Totalità e Infinito* (Jaca Book, Milan, 1980), p. 73.

[39] Cf. *Salvifici Doloris*, n. 29.

[40] C. MELITELLO, 'Donna e Mistero', *Camilliani*, 65 (1993), p. 110. See in this article the pertinent reflections on Mary of Nazareth, the model of priestly and royal prophetic ministeriality (pp. 110-111).

[41] S. LEONE, 'Salute: Approccio Etico-Pastorale', in *Dizionario di Teologia Pastorale Sanitaria* (Camillianium, Turin, 1997), p. 1097.

[42] *Ibid.*, p. 1093.

[43] *Ibid.*, p. 1093.

[44] The encyclical *Evangelium Vitae* of John Paul II describes in exhaustive fashion the attacks on life which are present in contemporary culture and which are visible in a particular way in the world of health.

[45] Cf. D. VASSE, 'La Parole e la Souffrance', *Medicine de l'Homme*, 82 (1976), p. 30.

[46] G. CINÀ (ed.), *Medicina e Spiritualità* (Camilliane, Turin, 1998), p. 9.

[47] G. MAGGIONI, 'Sofferenza, Approccio Biblico (NT)', in *Dizionario de Teologia Pastorale*, p. 1171.

[48] B. HAERING, *Perspectives Chrétiennes pour une Médicine Humaine* (Fayard, 1975), p. 157.

[49] Cf. *Exposition on the Book of Psalms*, 44, 3; *PL* 36, pp. 495-496.

[50] B. UGUEUX, *op. cit.*, pp. 192-193.

[51] Cf. G. CINÀ, *op. cit.*, pp. 10-11: cf. B. Ugueux, *op. cit.*, p. 204.

[52] Cf. B. UGEAUX, *op. cit.*, p. 203.

[53] G. Cinà, *op. cit.*, p. 9.

[54] B. UGEAUX, *op. cit.*, pp. 27-28.

[55] G. CINÀ, *op. cit.*, p. 11.

WILLEM J. EIJK

II: Contemporary Questions of Moral Theology

Catholic moral theology has as its point of departure a vision of man based upon Revelation or Christian philosophy, above all of the Thomist kind. God, in creating man in his image and likeness, had a certain plan for man which corresponds to his being. This approach means that man, reflecting on his own being, either rationally or in the light of Revelation, is able to know what behaviour is appropriate or not appropriate to his being. In other words, man is for this reason able to discover what is needed to strengthen his likeness to God. This is realised through the virtues, above all those infused in him as a grace of God. Gregory of Nyssa said that 'the end of life led in line with the virtues is to become similar to God'.[1] Thomas Aquinas saw the virtues as moral characteristics which strengthen within man his likeness to God.[2]

Autonomy and Pluralism

This fundamental approach was challenged above all else during the last century by a series of coinciding factors which made it almost impossible for modern society to provide an answer to what man is and thus to the question of how he should be and how he should act. The founder of situation ethics, the German thinker Eberhard Grisebach (1880-1945), Professor of theological ethics at the Faculty of Protestant Theology of Zurich, wrote in his book *Gregenwart*, which was published in 1928: 'It cannot escape the critical thinker that scientific ethics, notwithstanding their fundamental absolute, do not tell any man what at any moment he must do here and now, they cannot guarantee that they will lead somebody to ethical existence in the contemporary situation'.[3]

Grisebach was convinced that universal norms cannot be derived from the essence of man. Attempts to do this, in his opinion, were based upon images made by man of himself and memories of the past, or were things which came from an apparent world. All this, thought Grisbach, distracted man from the concrete situation in which he acts. Each and every situation is for him so unique that no universal rule could be applied to it. In this thought one can recognise the approach of nominalism, something which has always greatly influenced Protestantism. During the last century there was added the influence of existentialist philosophy which placed even greater emphasis on the unique and the concrete.

It is clear that nominalism, which reduces human knowledge to the empirical, is a very attractive philosophy in an epoch when science and technology still enjoy very great authority, although such au-

thority is less than it once was. The law of David Hume (1711-1776), which is often referred to, says that there is an insuperable leap between what is and what ought to be.[4] That is to say that a knowledge of the facts can never tell me how I must act (in English this is described as the fact/value dichotomy). This is a logical consequence of Hume's empiricism. This should not lead us, however, to close our eyes to the fundamental weakness of empiricism, which is in fact based upon a blind and self-contradictory dogma. Indeed, it cannot be demonstrated in an empirical way that only empirical knowledge is real knowledge, although according to the fundamental dogma of empiricism this in fact is the only way by which to arrive at real scientific knowledge.

Another very important factor is that according to the natural and technological sciences every method, every result of research, and every natural physical law formulated in a certain period can also be subjected to proof or further experimentation. This gives the impression that almost every form of human knowledge is always changeable, not only in the field of science and technology but also in that of philosophy and theology, and – and this is an important fact – in the field of ethics as well. The theory of evolution, which presents man as a non-intentional product of an impersonal causal biological process, has taken the place of the creationist vision and for this reason has also displaced the conception of the plan of creation as the basis of morality.

The positivist mentality also has as a consequence that Holy Scripture is often interpreted only according to the criteria of the positive sciences and that its specific message is rejected. Fundamentalism, which is present above all else in orthodox Protestants but which at times is to be found in certain Catholic groups as well, tries to maintain faith and traditional Christian morality by taking the Bible literally. This, however, is in the final analysis an expression of the same empiricist and nominalist approach.

Whilst classic morality, although it had lost its basis, continued to be generally accepted within society until the last twenty-five years of the last century, it was lost during the epoch of the hippie movement and the sexual revolution. A very important factor in bringing this about was the prosperity which arose in the United States of America during the nineteen fifties and emerged in the second part of the nineteen sixties in Western Europe. Prosperity and technology made daily life less harsh and more comfortable and caused a major change in norms and values. What was severe and demanding easily became seen as something which had to be avoided in a moral sense. Catholic moral doctrine was thus often seen as inhuman – how could one, for example, require a girl who had become pregnant against her will to carry that pregnancy to its natural conclusion? The consequences for her life, it was thought, were too serious and severe for such a thing to be required. Indeed, many people who say that they reject induced abortion generally make an exception in such a case.

An absolute norm, that is to say a norm which prohibits a concrete intrinsic evil, allows of no exception, and for this reason arouses suspicion in our society. A doctrine which still upholds the existence of absolute norms is rejected as legalism and thought to be overly rigorous.[5] Fletcher, a Protestant adherent of situation ethics, has described the approach of society towards those who proclaim absolute norms in the following way: 'even if the legalist deplores the fact that the law requires hard and disastrous decisions, he still shouts "Fiat justitia, ruat caelum" (let justice be done even though the heavens fall). He is the man whom Mark Twain called "a good man in the worst sense of the word"'.[6] Most of contemporary sets of ethics and moral theologies are today inclined to see norms such as 'I would not engage in induced abortion or direct euthanasia' as *general norms,* that is to say as norms which are valid in general but which are not without exceptions ('valent ut inpluribus'), and which are therefore in opposition to absolute norms.

Discussion on the foundations of the moral norms of moral theology advances in two stages at an overall level. Situation ethics, which is favoured for the most part by liberal Protestants, dominated during the fifties and sixties. Amongst Catholic moral experts who found traditional morality too restrictive, proportionalism was generally accepted from the middle of the nineteen sixties.[7] Leaving aside its various variations, this current of thought had as a principle the assertion that in the concrete act both the positive and the negative effects have to be considered in order to establish whether an act is good or bad. One has, for example, to weigh the death of an unborn child against the negative consequences for the life and career of a girl who has become pregnant against her wishes. Intrinsic evil, that is to say evil which should never be done, however good the goal aimed for, is said to involve only the approach of the agent or a virtue in general – one should not, for example, ever act unjustly or imprudently. However, proportionalism was rejected by the Magisterium in the encyclical *Veritatis Splendor* (nn. 71-83).

Whilst classic utilitarianism and proportionalism – which was to a certain extent its expression in Catholic moral theology – saw ethical judgement, that it is to say the drawing up of a suitable balance of positive and negative consequences, as being not only the task of the individual moral conscience, but in large part also as being the task of society or the public authorities, in actual fact their evaluation and assessment has become increasingly something for the individual. The crisis of authority in general, which at the present time is, however, somewhat diminishing, makes the acceptance of public

authority and ecclesiastical authority above all in ethical questions difficult. Individualism and the lack of solidarity which are so conspicuous in Western society have as their consequence that man becomes increasingly more closed up within himself. Each and every man has his own standards by which to judge the meaning of his behaviour and the consequences of his actions, and for this reason he is said to be in large part autonomous. The ethics which seek to support this development are known as the ethics of autonomy.

Such ethics prevail in secularised society but they have also had a great influence upon religious believers. Every pastor of souls is faced with this attitude among his parishioners and hears said to him 'I can determine what I believe'. In public life, medical doctors, nurses, teachers, social workers and many others have to conceal their own beliefs behind the mask of their professional role and activity. In health care it can easily happen that a medical doctor does not agree with his customer but every ethical discussion draws to a halt before the autonomy of the patient – 'this is something that he himself wanted'. Given that the balance of the various relative values is often based upon the emotions of the moment the result is not communicable to other people. It is very significant that here one does not speak about an 'ethical judgement', which can be communicated through rational discourse, but of an 'ethical decision' – this is an example of extreme voluntarism.

Western society was still experiencing during the years of rebellion and conflict – that is to say during the nineteen sixties – a frequently severe struggle between the various currents of thought and indeed between the generations. But we have now accepted that autonomy and pluralism are indispensable pre-conditions for peaceful co-existence despite the presence of a diversity of ethical opinions and choices. We are dealing here with deontological ethics in the sense that a series of principles (normally four in number) are taken as a point of departure, and these are based upon a simple model. Given the impossibility of achieving an ethical consensus which can then act as a leading plan for the legal system it becomes necessary to confine ourselves to those empirically verifiable principles which are accepted by everyone as constituting a 'highest common denominator'.[8] These principles are as follows:

1. The principle of autonomy or – in a somewhat attenuated way – the principle of permission.
2. The principle of doing good (the principle of beneficence).
3. The principle of not doing harm (the principle of non-maleficence).
4. The principle of justice.

Nobody can deny the principle of autonomy because man is obviously a free being. Many people see this principle as the fundamental principle which always and everywhere requires obedience and which has a priority over the principle of doing good. If a person wants to end his own life through euthanasia or change his sex nobody has the right to stop him. This means that a medical doctor, in trying to save the life of a person who wants to take his own life, does a good but does this against the will of the patient. This means that he commits the sin of paternalism. If somebody, instead, does not accept euthanasia in principle he must not impose it. In this way a traditional Catholic and a liberal can live together peacefully within the same society.

Through democratic consensus, society tends to establish certain goods in order to distribute them among the population in line with the principle of justice, and this with a view to allowing all people able to live out their autonomy to the highest degree possible. Society, in the same way, does not have the right to impose on an individual a good against his wishes. The principle of not doing harm functions as a negative barrier in relation to autonomy – to cause harm to another person is not acceptable because this can be understood as a limitation on that person's autonomy.

It is clear that it is impossible to reconcile the ethics of autonomy with Catholic morality. This latter takes as its point of departure an anthropology which has certain fixed co-ordinates which are themselves independent of any possible subjective preference.

Given that autonomy and pluralism exclude *a priori* fundamental discussion in the public forum it is first of all necessary to demonstrate their difficulties, and even their intrinsic impossibilities.

Illusory Ethics

Precisely in relation to those principles which should lead society to a consensus, the ethics of autonomy demonstrate a fundamental defect. Above all else the principles of doing good and of not doing harm and of doing justice have no meaning unless one knows first of all what good and harm are, or what rights are, or what justice is. What do these principles listed above actually involve when such concepts do not have any objective contents?

In 1988, the Court of Luxembourg gave a judgement in the case of men who had damaged the external genitals of some members of their group during the carrying out of sado-masochistic rites. Both those responsible and the victims themselves defended themselves by saying that everything had taken place with the consent of the victims. The Court, seemingly convinced that a citizen does not have the right to dispose of his or her own body in an unlimited way, rejected their arguments. However, there remains a certain contradiction in the legal system because another action in which the body is wounded in a marked way because of a wish which takes place at a sexual level, that is to say the sex change operation, is generally accepted because it is seen as a form of treatment. And some countries tolerate the use of light drugs, which in actual fact are not light at all, or heavy drugs, even when supplied free in desperate cases, to prevent theft or other forms of crime. This is done within the framework of so-called 'harm reduction' in order to protect the principle of not doing harm. But what is the criterion for the evaluation and assessment of the various effects? There is a lack of logic when we compare the two cases: if we accept the modification of gender why should we not accept sadistic wounding which is practiced in order to enable certain people to satisfy their deviant

sexual desires which would otherwise become uncontrollable? Why should we not see this as well as a sort of therapy or preventive measure? The impression remains, therefore, that the ethics of autonomy are not without a certain major arbitrariness, in the social field as well. This makes one fear that one day the approach to sadistic harm could, on the basis of mutual agreement, become positive in character. In his encyclical *Evangelium Vitae* (n. 70), John Paul II asks whether such an arbitrariness, which denies even such fundamental goods as life, does not in fact lead to a democratic society becoming its opposite: 'when a parliamentary or social majority decrees that it is legal, at least under certain conditions, to kill unborn human life, is it not really making a "tyrannical" decision with regard to the weakest and most defenceless of human beings?'

Side by side with the problem that the lack of an anthropology which supplies objective criteria by which to distinguish good from evil in fundamental terms makes any moral evaluation impossible, autonomy in itself appears to be a fiction. We discover this when we analyse certain cases which are seen as being examples of autonomous decision-making. We should we think about the autonomy of the transsexual who wants to modify his phenotypic gender? Is it or is it not a completely autonomous decision? It is certainly the case that he has not chosen the condition of being a transsexual – according to the experts this is both the result of a psychological development and the expression of a biological/genetic condition. Whatever the cause may be, the decision to undergo an external sex change seems, however, at least partly, to be determined by factors which evade free will. Can we not say the same about all cosmetic operations?

In truth, why do people want to engage in piercing and have tattoos done on their bodies? Why is it a pleasure to go outside in a sleeveless shirt despite the cold so as to show people one's muscular arms and shoulders. Why do people have face-lifts and cosmetic implants? Why is there this dissatisfaction with one's body as it is when there is no illness or defect? Without sharing the philosophy of Sartre, one must agree with his description of the contemporary mentality, by which he, too, was oppressed. We often feel that we are being watched as objects by other people who reduce us to an object and a possession.[9] Shame comes into play when we become a thing appreciated according to its value in the eyes of another person. This approach concerns the body. If the gaze of the other person threatens to destroy me, I have to remove the cause.

There are those who train the body, have plastic surgery, engage in piercing and tattoos, and they do this voluntarily, indeed are not constrained to do so. However, the body functions in our culture as an object which attracts the attention of other people. In what we do with our bodies we are led by the preferences of other people. Fashion is not a personal choice – it is determined and imposed by a group or by collective pressure.

In more intellectual circles, as well, man is rather like a saleable object. In a recent article in a Dutch review a survey was described which had been carried out into the extent to which external beauty and attractiveness influenced levels of income and the ability to achieve advance in one's career. Such factors were found to be proportional. A plastic surgeon at Schevengen for this reason regularly treats well-known high-level managers from the world of business. Amongst them was to be found a man in his forties whose face was in no way ugly. In the IT industry where he worked 'among young people' he wanted to appear more 'cool'. 'He did not fail to notice the fact that one's eyelids begin to droop a little as one approaches the age of forty. This gives the impression of being tired and the answer is to cut". This operation involves the removal of a lay of fat – 'one of the most popular operations among middle aged women, and in addition not very expensive. It can be done for 3000 florins (2.500.000 Italian lire)'.[10]

Many things done to the body come from feelings of inferiority, something which is rather frequent in a demanding society such as ours. A choice determined by these feelings which function in the ultimate analysis as forms of social pressure is not completely free or autonomous. The problem with the ethics of autonomy is that these are ethics without a subject – the autonomous man which they envisage is an abstraction or perhaps even an illusion.

Even if the autonomous individual existed he would have a task which could not be met – he would be 'condemned' to engage in a constant comparison between the various relevant goods in his situation. Without a fixed co-ordinate this is impossible. How could one compare the weight of the various goods involved in a human act given that they are not commensurate with each other when there is no common denominator? How can one assess the value of a step forward in one's career or a trip to Thailand rather than having a child or the importance of procreation for demographic balance?[11] One is not dealing here with goods of the same order. Demmer looks for such a common denominator in 'openness to eternity' *(Ewigkeitserschlossenheit):* 'the temporal with the eternal are not compared or even mutually assessed, but rather distinct degrees of intensity, awareness and freedom of openness to eternity'.[12] This proposal, however, is a solution which gives rise to a certain perplexity. The ethics of autonomy impose on individuals a task which is psychologically too difficult to perform. The individual in himself is not able to have an overall vision of things. Freedom of choice has in addition other disadvantages. Life no longer has an obvious path but a series of personal choices for which the individual himself is totally responsible. The consequence of this is that, no longer supported by society, although he is personally appreciated

for his success he is also held personally responsible for his own failure.

The drama of the illusion of the autonomous man becomes even clearer when we consider what happens to him in his social relationships. In public discussion it is almost impossible to speak about one's own religious or political beliefs because they are limited to the private sphere. The consequence of this is that in social and political life we become forced to discuss only those values which are important for everybody. In practice this means economic values. As a result man himself is practically reduced to an economic value. The English philosopher MacIntyre observed how the leading social models of the past – professors, medical doctors, lawyers and pastors – have been substituted today by bureaucratic managers.[13] The manager is the person who must manage a company, a hospital, a school, or a public entity by utilising the minimum of resources, money and employees. From this point of view, man is often assessed only in terms of his economic value and not primarily according to his being, which, however, he has wanted to put forward by emphasising his autonomy. This contrary consequence shows that the ethics of autonomy in the final analysis are only an illusion.

An Objective Support

The fundamental question is if there exist objective goods which function as fixed co-ordinates for an ethical evaluation of human behaviour. Human freedom is certainly such a good but it is exalted to the state of being almost the only fundamental human good without reference to the others. Modern man, in living with the illusion that without health life is deprived of all value, surrenders when the technology is not there and increasingly chooses the active termination of life in the form of assisted suicide or (voluntary) euthanasia. The freedom to evaluate the value of life is preferred to life itself. Although freedom is the highest good of man should we not state that life is a more fundamental good? Cardinal De Lugo (1583-1660), according to St. Alphone of Ligorio the greatest moral theologian after St. Thomas Aquinas, called suicide a sin against the love of man towards himself because life is 'substantia et fundamentum aliorum [bonorum]' – 'how can I love myself if I do not want for myself at least being which is the basis of every good and without which I cannot wish for myself any good?'[14] Without life one cannot achieve freedom.

Whilst in contemporary Western society there is a strong tendency to prefer freedom over choice, there are also other experiences. We can really be amazed at the fact that people in terrible and apparently unbearable circumstances strive even *in extremis* to survive. The concentration camp prisoners of the period of Nazism and Communism demonstrated a strong will to survive, despite the fact that their situation was desperate. In his famous book, *The Gulag Archipelego,* A.Solzhenistyn gave many meaningful examples of this.[15] During imprisonment in a concentration camp the Viennese psychiatrist Viktor Frankl had an opportunity to carry out research into his logotherapy, the model of the third school of psychotherapy of Vienna, in observing that prisoners managed to survive by keeping their hope alive and by perceiving a meaning to life.[16] When they lost such things they were no longer able to live and they usually died, without being killed or committing suicide. This shows that man, even in circumstances which are much more severe than those experienced by our terminally ill patients, has a propensity to live and thus to see life as a good.

The same holds true for procreation – there was a great love for, affection towards, and wish to have children even in epochs in which good diets and education could be achieved only with great effort and many difficulties. Although during wars the birth rate falls, there is often a rapid increase during the immediate post-war period. Despite the very low birth rate to be encountered in our society, a major part of the 20% of the couples who cannot have children in a natural way are ready to undergo a large number of medical exams and operations in order to procreate. This means that even in our society procreation is still seen as a good.

There are other goods which man wishes to have. Solzhenitsyn himself describes how the interrogators in the Communist system used tried and tested methods to force prisoners who were often completely innocent to sign confessions as to their guilt – they made a number of false promises ('if you sign we guarantee that you will be treated in a mild way'), they deceived them by pretending that their families had also been arrested and that they fate depended on a rapid confession of guilt, or they tortured them so that they could no longer think. By

depriving them of objective rational consciousness they prevented them from acting in a human way, that is to say as free and responsible beings. Hence the principle of informed consent which requires that a patient must not undergo treatment or take part in an experiment if he has not been sufficiently informed about the advantages and disadvantages involved, or if he has been subjected to pressure. Otherwise he could not take a really free decision. In this context, knowledge, too, is a fundamental good in the achievement of freedom.

The newly-born children of the experiment carried out by Frederick II during the thirteenth century were not caressed and nothing was said to them. This was to see if the original language of man was Hebrew. They all died. One reason for asking for euthanasia is often the

feeling of being abandoned and isolated. Despite prosperity, many people in our society suffer from loneliness, the illness of the Western world. Practical knowledge or wisdom in themselves are not enough to enable us to live, as indeed Frankl points out: 'in a concentration camp I once found the body of a woman who had committed suicide. Amongst her possessions was a piece of paper on which the following words had been written: "Courage to bear destiny is stronger than destiny itself". Well, despite this motto, she had taken her own life. Wisdom is diminished if there is an absence of human touch'.[17]

All this shows that affection and relationships with other people, as in part emotional and in part spiritual goods, are indispensable for man in order to live in a human way. These reflections show that the absolutely autonomous man, in the sense that he can determine what a good or otherwise may be for him, is a total abstraction in relation to reality. Whereas many people think that the classic doctrine of natural law is too abstract to form the basis of ethics, in actual fact it also corresponds to the concrete experiences of man during the twentieth century. A 'sine qua non' condition, however, is that this should not be presented in the voluntaristic and essentialist way as was done by the moral thinkers of the second scholastic period. This explanation of natural law lost ground during the nineteen sixties of the last century because of the accusation that it was biologistic and physicistic. Indeed, one cannot deduce moral norms merely from biological facts without referring to the being of the person in his wholeness.

The original Thomist interpretation did not see a norm as the basis of morality – this basis was, rather, the end written into the being of the human person as such. Thomas Aquinas formulated the first precept of natural law in the following way: 'good is to be done and to be sought for, evil should be avoided'.[18] Like Aristotle before him, Thomas Aquinas identified good with ends. The precept formulated in this way seems abstract but it actually receives concrete contents through propensities. Man has certain basic propensities towards things which reason spontaneously perceives, for this reason, as goods, and these are as follows:

1. The propensity to maintain his own being, something that man has in common with the other substances, from which it follows that life is a good.

2. The propensity to maintain his species through procreation and the raising of children, something that he has in common with the animals.

3. The propensity specific to man, namely his aspiration to rational knowledge and to live in society.

Many people have difficulty in accepting this explanation of knowledge of moral principles based upon human propensities. Does this not reduce man to the level of an animal which has determined behaviour? Let us not forget that the concept of nature and of natural law makes modern man think that one is dealing here with biological/natural nature and physical natural laws which imply determined functions or effects. Modern man has precisely the belief that he has overcome physical and biological nature, which often has a large number of limitations. He gets angry or he gets irritated when reality seems to be the opposite. The concept of natural law is for this reason less popular. Whatever the case, aversion towards this concept is based upon a misunderstanding – propensities are conceived as blind tendencies, which they obviously are not. They are, in fact, the beginning of moral action because they place man face to face with a choice. Without the existence of certain things that man automatically perceives as goods requiring his positive or negative answer there would be no freedom. Without an objective point of view man can only follow his passions, his emotions and his biological instincts, which obviously determine his behaviour because they are blind. In other words: if an objective criterion is lacking man is condemned to behave in a blind way. The denial of every objective criterion thus means the death of autonomous man.

One can, however, speak about natural law and avoid this term. Some people have tried to formulate the objective fundamental criterion in a way that is a more acceptable to modern man. Finnis, taking not only the question known as 94.2 of the *Summa Theologica* but also all the other writings of Thomas Aquinas as a point of departure, identifies seven fundamental goods: life (including procreation), knowledge, play, aesthetic experiences, social life or friendship, practical rationality, and religion. Other goods can be listed but these can be reduced to one of these seven.[19] These last are fundamental in that they cannot be reduced to each other. All seven are equally fundamental – there is no hierarchy amongst them and one of them cannot be sacrificed to another. Anthropological research, amongst non-Western peoples as well, has indicated that these values can be found in very different cultures despite the concrete differences that exist between them. As has already been pointed out, a comparison of goods is only possible if there is a common denominator – the human person. The goods which are intrinsically rooted in the human person can not be compared to each other when a violation is involved. Only at the level of achievement can a comparison be made. In this way it is possible to engage in a comparison which is realistically based upon fixed co-ordinates.

The reader might be amazed to read that fundamental goods are in themselves known, that is to say not demonstrable. However, we are speaking here about the philosophical approach to ethics which, like metaphysics, is based upon evident principles as a point of departure. Basing ourselves on Revelation we would encounter no difficulty in indicating what these fundamental goods are. Holy Scripture calls man's life a special gift of God. Referring primarily to Genesis, the encyclical *Evangelium Vitae* affirms that *'the life* which God offers to man *is a gift by which God shares something of himself with his creature'* (n. 34). He himself is created in the image of God: 'The life which God gives man is quite different from the life of all other living creatures, inasmuch as man, although formed from the dust of the earth (cf. *Gen* 2:7, 3:19; *Job* 34:15; *Ps* 103:14; 104:29), *is a manifestation of God in the world, a sign of*

his presence, a trace of his glory (cf. *Gen* 1:26-27: *Ps* 8:6)... Man has been given a *sublime dignity*, based on the intimate bond which unites him to his Creator: in man there shines forth a reflection of God himself'(Ibid.). However violated, modest and insignificant, living man remains a 'manifestation of God' in this world and has a 'sublime dignity'.

Not only the specific origins but also the ultimate end of man demonstrate that life is an essential good. On the basis of the promise of eternal life, made to us by Jesus, we know that final destiny consists of blessedness in a friendship with God where we know Him and love Him face to face (*ibid*., n. 38). All this upholds and affirms the goods of life and knowledge. The fact that man exists in the final analysis for a relationship with God means that inter-subjectivity is also a fundamental good.

Despite the clear answers provided by Revelation and by the doctrine of the Church, we cannot, however, disengage ourselves from proceeding also at a philosophical level because the religious approach easily gives rise to misunderstandings and resistance but above all else because Holy Scripture itself directs us to the order of the creation in order to establish ethics (Rom 2:14-15).

Moral action is to be placed in the following perspective: man must not violate these corporeal, psychic, social and spiritual goods, but realise them in the right way. Otherwise, he will not be able to really contribute to the objective happiness of man.

From Goods to Norms, Virtues and Spirituality

The goods listed above belong to the first level of natural law which we know in the form of a 'habitus' given to man through the creation. The precept that one must do good and avoid doing harm is known through instinctive perception, whereas the experience of propensities to various things makes them known spontaneously as goods. The fundamental goods, therefore, are evident in themselves ('per se nota').[20] This knowledge, however, is not enough. We must also know in which way we have to realise these ends because they can be known in a non-ordered way. One can realise the good of knowledge by treating human beings as instruments in medical experiments, that is to say by violating the good of their life and their physical integrity. The first level of natural law would not be complete if it did not also contain some indications to this end. Thomas Aquinas lists the following as being at this level: the golden rule 'do unto others as you would have them do unto you' (Lk 6:31); Tob 4:15; Mat 7:12);[21] the principle of not doing harm or damage;[22] and that of practicing love for one's neighbour and love for God.[23] Here there are certain principles proposed by the ethics of autonomy but Thomas Aquinas does not fail to first indicate the contents of good and harm. Some moral experts have broadened this list with principles which bear upon how these goods can be realised. For example, Grisez lists eight, which he calls 'modes of responsibility'[24] and which are embodied in the virtues.[25]

The fundamental values are still not norms but only ends. How can we draw up concrete norms? One of the requirements of practical rationality, which comes from the principles mentioned in relation to the way in which the seven listed goods can be realised, is that they must be respected in every action and never be violated. On this, for example, is based the norm according to which one cannot kill an innocent person through abortion or direct euthanasia in order to realise another good. Thus one comes to the formulation of the conclusions which spring directly from the first level of natural law and which belong to the second level of natural law. One is dealing here with the norms of the decalogue (with the exception of the third which concerns the Sabbath day), which prohibit the violation of the fundamental goods and which are, therefore, absolute – that is to say they do not allow any exceptions. They are called the absolute minimum limit of love in the encyclical *Evangelium Vitae* (n. 75): '*The negative moral precepts*, which declare that the choice of certain moral actions is morally unacceptable, have an absolute value for human freedom: they are valid always and everywhere, without exception. They make it clear that the choice of certain ways of acting is radically incompatible with the love of God and with the dignity of the person created in his image. Such choices cannot be redeemed by the goodness of any intention or of any consequence; they contradict the fundamental decision to direct one's life to God'.

This second level of natural law is known by most people who have learning and formal education – up to a certain point in no culture are human life, procreation, marriage, honesty and social order seen as being completely neutral. This does not remove the fact that individuals and at times entire peoples can be blind to certain values, and this is a fact that the Christian tradition sees as one of the consequences of original sin. Whereas during the last century Western society found a more or less satisfying answer to the social question of the West, today it is not sufficiently aware of the value of human life or of marriage as a stable pact. For this reason, God expressly revealed natural law in the decalogue although it is in principle knowable to all men.[26] This continues in the task which befalls the Church – to proclaim natural law, as well, as a basis of moral action (cf. *Dignitatis Humanae*, n. 14).

An obvious objection would be that although most men see life as a good, there are some who, in extreme situations, do not see it as such: a terminal illness involving unbearable suffering, for example, or an unwanted pregnancy. It is not our intention to condemn those who resign themselves and trade their lives. To understand the situation does not mean, however, to approve everything. Quite apart from the theological explanation, which says that because of original sin emotions can make a person blind to an objective good and impede him from responding to that good in the right way, we must ask ourselves: if a person is no longer able to recognise a good – and this is something which is always the case when he has lost hope and courage – must we accept his situation and do nothing? Euthanasia in such a situation is to affirm hopelessness rather than

to affirm the loss of the value of life. Here we encounter once again an illusion. The choice of death as a man is not in the least an autonomous choice because the fact is that hopelessness and loss of courage take away freedom.

In applying the norms of the second level of natural law to more concrete cases we pass to the third level of natural law. Here a choice must be made in relation to the realisation of goods, for example in the case where it is asked for how long one should prolong the life of a patient using medical techniques. The norms of the third level are not absolute but general – they are valid in most cases but involve exceptions (they are valid 'semper, sed no pro semper' or 'ut in pluribus'). In the application of these norms one must evaluate and assess which act is proportionate to the realisation of the good in question and which good should preferably be realised.

To violate a good always implies the abandoning of a good because one lacks the hope that it will be realised or continued. It implies, therefore, a negation of oneself as an autonomous person. To require the legalisation of euthanasia does not mean to affirm real autonomy, that is to say the intrinsic autonomy of man, but only to ask for extrinsic autonomy, negative liberty, the freedom to kill oneself without the law intervening. To deny fundamental goods and thus to deny real human freedom can never lead man to real happiness. The solution cannot be the negation of the good as such, but finding the path of real freedom so as not to violate, but rather to realise, this good, even though this latter course is certainly difficult. But how can we find that real autonomy and that real freedom which lead to real happiness?

After the death of a man caused by aphasia who had been in a hospice for many years, all the other patients in his ward felt sad. They missed this man although they had not been able to exchange a word with him. The reason was that although he was suffering from aphasia he always had a radiant face with which he encouraged them. In this case every form of utilitarianism or functionalism of human dignity and of inter-subjective relationships does not know what to say. Why should such a man in such a condition be happy? His happiness, which led to an inter-subjective therapeutic result and which was very communicable, is certainly not to be found in health understood as complete well-being. The answer is that the presence of any kind of physical imperfection in the final analysis does not matter in relation to happiness – what counts is the approach of the person towards it. Suffering, although it is a natural reaction of man to the harm he receives,

is not a determined reaction: man, because he is a spiritual being endowed with freedom, and not merely in the hands of emotional-physical emotionalisms, has the opportunity to guide his reactions. The pre-condition to this, however, is that he is able to dominate them through the spirit. This is possible to the extent to which he knows how to relate his decisions to concrete reality through prudence, relate his fear and anxiety to reality through strength, and resist the seduction to exploit human biological nature with reference to justice for ends which are often illusory. To summarise, the person in question must have the virtues to be free, that is to say to be really autonomous. The instinctive perception that man must be free in order to be happy is right but what human autonomy actually constitutes is quite another question.

For every man the virtues are the essential necessary condition for autonomy, the capacity to take decisions which are proportionate to his own being in order to obtain happiness. At the same time they are communicable, as is shown by the man afflicted by aphasia, and thus offer a more solid basis for shared ethics in a pluralistic society than the so-called 'Georgetown mantra' – the principles of autonomy, of doing good, of not doing harm and of justice, which are not enough to define the contents of both autonomy and of good and harm, and close man up in illusory ideals, which are in fact determined or socially imposed, as we have already observed (these principles are called the 'Georgetown mantra' because they are almost used as a kind of magic formula – mantra – to solve every ethical dilemma, and in addition were produced at Georgetown University).

The autonomy of man in this sense is also necessary in order to open oneself up to absolute happiness. Since suffering in the ultimate analysis is violated love between man and the Creator, the path by which to defeat it involves giving an affirmative answer to the salvific love offered to us by God through Jesus. To open oneself to love is always a free act, that is to say it is autonomous. The core of the Christian message is that man, having received the theological virtues and the gifts of the Holy Spirit and having been redeemed and re-established as the image of God through being on a level with the Son of God (Jn 13:15-34; Eph 5:2; 1 Jn 2:6), finds his full happiness in inter-subjectivity with God through whom he becomes a participant in absolute love.

One should observe that we are crossing here the bridge between morality and spirituality. During Easter 1990 I was admitted to a hospital in Rome. The internal doctor who treated me told me that a little time beforehand he had heard a conference of a moral expert on induced abortion. During the discussion which followed he got up and said: "I am very sorry but what we medical doctors need is not a speech on moral norms but a spirituality for medical doctors". He did not want to say that morality did not convince him. Neither spirituality nor the virtues are in themselves a source of moral norms. Both come from the first level of natural law in the sense that they are so to speak 'the embodiment' of the principles which point out the path by which we can realise fundamental goods. This does not remove, however, the

fact that my doctor was right – one cannot provide a complete framework of medical ethics without speaking about the spirituality which is realised in the virtues, both in those acquired and those which are infused through grace, that is to say the theological virtues (faith, hope and charity) and the gifts of the Holy Spirit. The acquired virtues strengthen the likeness of the image of man to God, increasing his freedom and his adherence to the fundamental goods, the virtues which are infused identify him with the Son of God, who was made man, the Perfect Image.

Prospects and Suggestions

We should not think that postmodernism will last for ever. I believe that during the next decades people will become increasingly aware of the void brought about by the lack of a metaphysically based anthropology which provides meaning and thus a fixed principal direction for our lives. We have only to think of the history of the people of Israel described in the Old Testament. This history shows an undulating movement between adherence to God and a lack of faithfulness which leads onto a state of uncertainty, crisis, and absence of leadership. One survey has demonstrated that the percentage of people who do not belong to a church has been constantly increasing. In 1958 the figure was only 24%; in 1999 it was 63%. During the same period the percentage of Catholics fell from 42% to 18%.[27] We should not be surprised at this decrease given that an entire generation has failed to transmit its faith to its children. However, although in large part outside the Christian framework, in those in particular who were born after 1960 there has been growing a belief in life after death, heaven, hell, and religious miracles.[28] One can observe that although the more traditional mentality which sees the mother working outside the home as a burden for the family, and which rejects adultery and fiscal fraud, has lost ground, opinions in relation to sexual relations before marriage and homosexuality have remained more or less the same. Above all amongst the young members of the various churches there is a greater adherence to traditional moral beliefs than is the case with elderly people (whether members of a church or not). 18% in 1991 and 22% in 1998 of young members rejected the idea of sexual relations between those who intended to marry each other, against a figure of 7% for those people born before 1930. The same results were obtained in relation to views on homosexuality and selective abortion.[29] Although the difference is not very great the statistics demonstrate nonetheless that one should not totally exclude a return to a morality which is more compatible with Christian morality. Even in a country which is very secularised such as Holland one can detect a certain wish to rediscover fixed co-ordinates in which to ground the important choices of life.

Empiricist culture, although it involves serious difficulties for the metaphysical grounding of morality, also has its own strong points. Although today an abstract theory or doctrine is not able to get to people, biographies and the examples provided by real people certainly do. People today are wary of words – as was observed above, up to a certain point this is more than justified given that they were often deceived by the great ideologies of the twentieth century – but they love the language of visible facts. Witnesses are trusted more than masters.[30] In opposition to moral theologians, a Mother Teresa of Calcutta, in strongly rejecting induced abortion and at the same time in offering effective help to all women and girls who found themselves pregnant without wanting such a condition, also had a notable impact on contemporary public opinion.

H.E. Mons. WILLEM S. EIJK,
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Notes

[1] GREGORY OF NYSSA, *Orationes de Beatitudines*, 1 (PG 44, 1200).

[2] THOMAS AQUINAS, *Summa Theologica* I-II, prologus; 55, 2-3; 68-70; *Expositionis in Lucam Liber*, V, 49 (PL 15, 1734); cf. *CCC, n. 705.*

[3] E. GRISEBACH, *Gegenwart. Eine Kritische Ethik* (Halle, Max Niemeyer Verlag, 1928), p. 187.

[4] D. HUME, *A Treatise of Human Nature*, III, 1, 1 (London, J.M.Dent & Sons), Vol. 2, pp. 177-8.

[5] B. SCHÜLLER, *Die Begründung Sittlicher Urteile. Typen Ethischer Argumentation in der Katholischen Moraltheologie* (Dusseldorf, Patmos-Verlag, 1973), p. 141.

[6] J. FLETCHER, *Situation Ethics. The New Morality* (Philadelphia, The Westminster Press, 1966), p. 20.

[7] Proportionalism was applied for the first time by the Dutch Domenican Willem van der Marck in his book (W.H.M. VAM DER MARCK, *Liedfe en Vrichtbaarheid. Actuele Bragen over Geboorteregeling* Roermond/Maaseik, J.J. Romen en Zonen, 1964). Proportionalism as such was systemised by the German Jesuit Peter Knauer in his classic article on the principle of the action with a double effects (P. KNAUER, 'La détermination du bien et du mal moral per la principe du double effet', *Nouvelle Revue Théologique* 87 (1965), pp. 356-376). Other known followers of proportionalism are: Josef Fuchs, Louis Janssens, Richard A. McCormick, Charles Curran, Bruno Schhller, Franz B`ckle and Klaus Demmer.

[8] The American philosopher and medical doctor Engelhardt directly introduced the ethics of autonomy into bioethics: H. TRISTRAM ENGHELDARDT, *The Foundations of Bioethics* (New York/Oxford, Oxford University Press, 2nd. edn.). In this second edition he replaced the principle of autonomy of the first edition of 1986 with the principle of permission.

[9] J.P. SARTRE, *L'Etre et la Néant. Essau d'Ontologie Phénoménologique* (Paris, Gallimard, 1943), p. 413.

[10] TH. VASSEN, 'Hoe Mooier, Hoe Rijker', *HP/DE Tijd* (2000), b. 30, pp. 27-33, quotation p. 31.

[11] B. VAN DER HAAK, 'Bevolkingspolitiek', *Trouw*, 21 October 2000, p. 19.

[12] K. DEMMER, *Gottes Anspruch Denken. Die Gottesfrage in der Motraltheologie* (Freiburg-Scweiz/Vienna, 1993), p. 94.

[13] A. MACINTYRE, *After Virtue. A Study in Moral Theory* (London, Duckworth, 1997, 2nd. edn.), pp. 23-25.

[14] J. DE LUGO, *Disputationes Scholasticae et Morales* (editio nova, ed. by J.B. Fournais, Paris, Lodovicus Vivès, 1869), C, I, n. 5, tomus VI, p. 38.

[15] A. Solzhenitsyn, *Arcipelago Gulag* (Mondadori, 1975), three volumes.

[16] V.E. FRANKL, *Man's Search for Meaning. An Introduction to Logotherapy* (New York, Simon & Schuster, 1975).

[17] V.E. FRANKL, *Senso e Valori per l'Esistenza. La Risposta della Lagoterapia* (Rome, Città Nuova Editrice, 1994), p. 23.

[18] THOMAS AQUINAS, *Summa Teologica* I-II, 94, 2.

[19] J. FINNIS, *Natural Law and Natural Rights* (Oxford, Clarendon Press, 1988, Clarendon Law Series), pp. 86-92.

[20] THOMAS AQUINAS, *Summa Teologica* I-II, 100, 3. 21. *Ibid*., 94, 4 ad 1.

[22] *Ibid*., 95, 2.

[23] *Ibid*., 100,11.

[24] G. GRISEZ, *The Way of the Lord Jesus. Volume I: Christian Moral Principles* (Chicago, Franciscan Herald Press, 1983), pp. 205-228.

[25] *Ibid*., p. 192 'the virtues embody the modes'.

[26] THOMAS AQUINAS, *Summa Theologica* I-II, 98, 6.

[27] J.W. BECKER AND J.S.J. DE WIT, *Secularisatie in de Jaren Negentig. Kerklidmaatschap, Veranderingen in Opvattingen en een Prognose* (Den Haag, Sociaal en Cultureel Planbureau, 2000), p. 24.

[28] *Ibid*., p. 46.

[29] *Ibid*., pp. 48-51.

[30] Madre Tekla Famigletti, forword to M.G. MASCIARELLI, *Beata Maria Elisabetta Hesselblad* (Turin, Elledici, 2000, 2nd. edn.), p. 8.

DIEGO GRACIA GUILLÉN

III: Medicine and Cultural Change

Introduction

The first day of this international conference on 'health care and society: technological challenges and the humanisation of medicine' was dedicated, in its first part, to a review of the contemporary situation of medicine and an analysis of the so-called 'emergent illnesses' of these last ten years, the new type of patient, the new health care professionals, the new place of health care, and new technology and its limits. After analysing the whole of this impressive panorama, the organisers of this international conference then dedicated a session to a critical and illuminating analysis of the whole of this new and complex reality beginning with a dual approach of a historical and theological character.

My paper seeks to locate the complex health care realities in which we find ourselves by analysing them from a historical perspective, with a glance back over the past and a glance at the future. This paper is divided into three parts and such will be its aim. In the first part I will seek to describe the role of illness in history, or of health and illness as historical realities. In the second part I will attempt to identify the historical stages through which the relationship of human beings with illness has passed. Lastly, in the third and final part, I will address myself to the contemporary situation and the prospects for the future. My hope is that this panorama will enable us to achieve a better understanding of that complex phenomenon, human illness, and to approach it from other perspectives – the ethical, the philosophical, the theological, the political, and all the rest.

1. Health and Illness as Historical Realities

History is the result of the interaction of human beings with nature. Human beings make history beginning with what they encounter, and what they encounter is, above all else, nature. Nature bears within it what are called 'natural resources'. Man, to live, needs to transform these resources into opportunities for the maintenance of life. For this reason, such opportunities are always human creations. Human beings create these opportunities by taking resources as their point of departure, and by this route they develop culture and make history. *'Resources' are natural, but 'opportunities' are cultural and historical.*

History, for this reason, is the process by which natural 'resources' are transformed into 'opportunities' for maintaining life. The earth has resources which can be transformed into opportunities, but this can only be done through the action of man. Thus, for example, coal is a mineral which enables us to produce fire, and with fire we can move locomotives, or heat houses. This, however, only happens if man transforms natural resources into historical opportunities through the invention of fire, the steam engine, etc. Oil remained in huge underground lakes for many centuries. As a resource, it existed many years before the origins of man, but it became a way of maintaining life with the invention of the combustion engine. At the outset it was merely a natural resource, and not a historical opportunity.

The transformation of resources into opportunities is an act of authentic 'creation'. Opportunities do not, in general, exist. It is necessary 'to create them' and 'to invent them'. The human being is an authentic creator of opportunities. However, he does not create them from nothing, in the way that God does. He can create opportunities but he can only do this by taking natural resources as his point of departure. He is not God, but, as Leibniz observed in his *Monadologia*, he is a 'little God', or as the Judeo-Christian tradition has it, he is the 'image and likeness of God'.

History is made up of the creation and the transmission of opportunities. The opportunities that we bring into existence, whether negative or positive in character, once they have been created, come to have a life of their own, and become independent of their creator – they become, that is to say, objectivised. This process is what Hegel called 'the objective spirit'. Michelangelo sculptured the wonderful 'Pietà' which we can admire here in the Vatican, located as it is in the basilica of St. Peter's. Once sculptured, the statue became transformed into a cultural fact which was endowed with its own life. It became independent of its artist and maker, who passed away, and this image has continued to be a fundamental part of our cultural, artistic, and religious life.

Precisely because they become objects, cultural creations constitute a kind of 'deposit' which is handed down to us by the generations which preceded our birth and which allow us to maintain life through the creation of new opportunities which also come to be a part of the deposit and which will be handed down to the next generations.

'To hand down', 'transmission' – in the parlance of specialists the term *parádosis* is employed, a term which was translated in Latin by the word *traditio*. *Parádosis* come from the ancient Greek root *dídomi*, which means to give, to give a present, to offer, and to hand over. The ancient Greek verb *dídomi* corresponds to the Latin *do*, to give, to hand over. From *do* comes the Latin *trado*, which means to bring, to transmit. Hence the noun *traditio*, which is thus a perfect translation of the ancient Greek term *parádosis*. Perhaps it is a good idea to recall that the same Latin root, from the word *do*, gave rise to many other words which are related to others which emerged before it. For example, *credo*, to believe. One always believes in a trusted deposit, in a tradition. Hence faith is also a historical phenomenon. One believes in a deposit which has been handed down to us.

History is thus the handing down of opportunities, of ways of being located in reality. This, indeed, was how history was defined by the Spanish philosopher, Xavier Zubiri, a few decades ago. We are different from all the other human beings who belonged to previous generations because we are present in reality in a way which is different, precisely because we have been entrusted with a deposit which, at least in part, is different and which offers us opportunities which are different from those possessed by every other previous generation. We can do things that they could not do. For example, we can go to the moon and carry out operations involving organ transplants, and modify the genome of animal species or even of human beings themselves.

What should be borne in mind is that the opportunities that human beings create in their relationship with nature can be positive or negative in character. Not all opportunities are positive, that is to say not all opportunities condition in a positive manner the life of human beings. Not all opportunities allow them to live better or to attain their ideals of perfection, happiness, etc. with ease. Certainly man has always sought to generate positive opportunities but it is also a fact – and this is something which has been repeated down the centuries – that he does not know how to produce them without in collateral fashion giving rise to negative opportunities, that is to say opportunities which have bad conditioning effects on the life of human beings, and which make them less human, less perfect, less happy. Man does not know how to create only positive opportunities, without at the same time generating ones of a negative character. He has not managed to do so so far, and probably he will never manage to do so. In history there happens what happens in the case of drugs and medicines, which, although they heal certain illnesses, also give rise to others. There is no drug or medicine which does not have negative or undesirable effects. There is no drug or medicine which does not have both positive and negative effects. The same happens in history. What we hand down to our descendants are positive opportunities, but we also transmit to them negative opportunities. Illness can and must be defined as a negative way of life. This means something that is very important, that is to say that illness is not in the majority of cases a merely natural phenomenon, a human resource. There are really very few illnesses which are only natural. In general, they are the result of the action of human beings in relation to nature, and for this reason they are historical in character. Illnesses are not mere resources but negative opportunities of life. Not to see them in these terms is a very serious mistake, which, even though not very frequent, is equally pernicious.

When has just been said about illnesses also applies to the fight against them, to medicine, and to health care. These, too, are human reactions, negative opportunities generated by man in his attempt to combat illness. Neither health nor illness nor health care can be seen as being on the confines of history. The objective of these reactions is to fight those negative opportunities of life which we call illnesses. But, as has already been observed, given that human beings do not know how to produce positive opportunities without generating negative opportunities at the same time, one can understand how medicine itself also generates illnesses. It is well known that to enter a hospital means to run a risk, not to speak of the risks run by entering an operating theatre or an intensive care unit. It is no accident that there are illnesses called iatrogenic, or that these reach surprising levels of incidence – always above 10%. Like pharmaceutical products, medicine, too, always has secondary effects.

2. Health and Illness in History

The history of mankind can be analysed from many points of view. But, if we wanted to be consistent with what has already been observed in this paper, the logical thing to do would be to see history as a process by which human beings are 'provided with opportunities', or as a process which transforms natural resources into opportunities of life. In this way it is possible to argue that a fundamental and historical cultural and historical change takes place when human beings find a new way, or a revolutionary way, of transforming resources into opportunities. For this reason, we can describe episodes when men discover a new way of transforming resources into opportunities as epochs or periods of change.

These periods of change have so far been two or three in number, or at the most four. In general they are seen as constituting revolutionary periods. Thus reference is made to a 'Neolithic revolution' and an 'industrial revolution'. These periods of change were not political revolutions in the way that the French revolution of 1789 was. Nor were they scientific revolutions, along the lines of the revolutions to which Thomas S. Kuhn called our attention a few decades ago. These revolutions were deeper and more radical in character because they involved the discovery of new ways of transforming resources into opportunities, which in turn involved another kind of revolution, which was political, social, cultural, or scientific etc. in nature.

The 'Neolithic' revolution gave

rise to history in a real and authentic sense. Indeed, the peoples and cultures which existed prior to that event have, because of this fact, been placed in the general category of the 'pre-historic'. This is due to the fact that the Neolithic revolution taught human beings the fundamental ways and routes by which resources could be transformed into opportunities, that is to say the practices of agriculture and stock-raising. Indeed, one might say that the birth of the so-called

'primary' sector was another outcome of this revolution. A revolution of the same importance and significance was not to take place until the eighteenth century, when the so-called 'industrial revolution' began. This involved the discovery of a new way of transforming resources into opportunities, and gave rise to the exponential growth of that economic sector which we call 'secondary'. Given that the capacity to transform resources into opportunities is called 'wealth', we can say that the Neolithic revolution enormously increased the wealth of mankind and that the industrial revolution increased it still further.

For many historians these were the two fundamental revolutions of the history of mankind. However, one should go further and add another which took place about a century ago when there was a move from industrial society to another kind of society, which we term 'post-industrial', a society of well-being or consumption. This change was less obvious or less surprising, but its consequences have been no less important. Indeed, it gave rise to an exponential growth of another sector of economic activity – the tertiary or service sector. Some good services are fundamental to the process by which human beings come to enjoy adequate life opportunities, and they thus constitute wealth. This is something which is less readily perceivable at the simple level with regard to this revolution than is the case with the two previous revolutions. Everybody knows that the advance of the primary and secondary sectors necessarily involves an increase in life opportunities. However, this is something which is less clearly the case with the tertiary sector. This is due to the fact that people do not sufficiently understand that history is a process involving 'the provision of opportunities'. Wealth, and I repeat the point, means a spectrum of opportunities. Wealth does not mean money, and even less natural resources. Wealth is not resources but life opportunities. There can be no doubt that a healthy tertiary sector is fundamental in the process of ensuring and increasing the life opportunities of human beings. At the roots of this new kind of society there was another industrial revolution, the so-called second industrial revolution, which emerged at the beginning of the twentieth century and was based upon the development of the combustion engine and the spectacular development and advance of communications and transport.

If these are the three great periods of change, or the three great historical revolutions of history, we can conclude from this that the whole of the history of mankind can be located around them and thus divided into four historical periods or epochs. The first, which goes from the origins of the human species to the Neolithic revolution, is generally known with the name of the 'pre-historic epoch'. The second is designated 'agricultural society'. The third receives the appellation 'industrial society'. The fourth, and last, is post-industrial society, which is also called the 'consumer' or 'well-being' society.

Each of these four historical epochs had very different durations. The only characteristic which they share is to have a duration which is shorter than that of the historical epoch which went before. For this reason, the periods of each of these stages became increasingly short. Pre-historic society lasted about three million years. It went from the origins of the human species, three or four million years ago, until the appearance of agricultural or pastoral society, which certainly did not take place before 10,000 BC and which we can locate with certainty to the sixth and fifth millennia BC. Agricultural society goes from this date until the middle of the eighteenth century. It thus lasted thousands of years. Industrial society lasted a much shorter period of time, about a century and a half. Finally, post-industrial or consumer society has lasted half a century, and it is still with us. The acceleration of history has meant that each stage lasted for a much shorter time than the one which preceded it.

After dividing up the history of mankind in this way we can now describe the fundamental characteristics of each of these historical epochs.

1) During the first stage, which involved the pre-historic populations, human beings almost did not know how to transform resources into opportunities, or in other terms they did not know how to create wealth. More than engaging in the creation of wealth, they destroyed it. These were predator peoples – similar in behaviour and lifestyle to animals – who could feed themselves only on what nature produced spontaneously for them. Hence their nomadic character and

way of life – they depended on natural resources and when these became exhausted they moved on to other locations. They did not create wealth but plundered nature of what it produced spontaneously. They were, therefore, hunters and gatherers.

Because they did not know how to transform these resources into opportunities, these people lived within a so-called 'mere subsistence economy'. This meant that they dedicated the whole of their labour to mere subsistence. They were not able to create surplus wealth. Hence the absence of great cultural, political, religious, scientific etc. institutions. However, it does not seem that mere subsistence was an easy matter. In fact, they led a very dangerous life, and were exposed to the hardship of the weather and engaged in a struggle against wild animals. Their food and diet must have been very poor. The fossil remains that are available to us indicate that they suffered from a condition generally known as 'defective' – they often lived on low caloric diets and fell into a state of malnutrition. Unfortunately, this phenomenon is still present in the third world. A specific culture such as pre-historic culture had a specific pathology, that of food deficiency. But there were other pathologies. For example, a great number of wounds or fractures, the pathology of the body structures, which was a consequence of hunting and the fight against wild animals. However, this protected them against those forms of illness created by abundance or civilisation and which are today so frequent.

Their form of medicine was very elementary. The most primitive was called 'empirical medicine', that is to say the form of medicine which animals possess. Experience, as Aristotle observed, was the result of the senses accompanied by memory. This is something which human beings share with the animals. As the Italian proverb has it: 'the scalded cat takes refuge in cold water'. The sensation of very hot water produces pain, and the memory of this pain means that the cat is subsequently afraid of hot water. This is an experience. The first form of medicine was of this kind. Like animals, human beings learnt to select certain herbs which had a purgative or laxative effect. It seems that these were the first drugs and medicines. It is no accident that the ancient Greek word *pharmakon* originally meant purgative or laxative. They must have also known about certain very elementary surgical techniques, such as cauterising wounds or the binding of fractures and luxations.

Under-nourished populations fall easy prey to illnesses and death. Their defences are weak and their biological resistance is low. This probably explains why the population growth rates of these people was almost zero, and in most cases actually negative. It also enables us to understand why almost all of them, with the exception of Cromagnon man, disappeared from the scene. This raises an interesting question – why did Cramagnon man not disappear, that is to say why was he able reach the moment when the Neolithic revolution begun, and above all why was he able to generate that revolution? We do not know the exact answer to this question but it seems clear that it had something to do with his greater intelligence and thus with his greater control over his environment. Indeed, during this vast epoch, which goes from the appearance of the first human beings to the Neolithic revolution, there took place events of immense transcendence. The most important of these occurred between 300,000 and 200,000 BC, depending on the region, during the middle Palaeolithic period, when Neanderthal man discovered the use of fire and begun to bury his dead. These two events were of an immense historical importance. The first allowed an enormous improvement in food and diet by making many things eatable through the use of fire and water which in the natural state could not be consumed. In this way these populations became omnivores. The burying of their dead demonstrates the existence of belief in a life beyond this one and thus testifies to the appearance of religious rites in the strict sense. This also had enormous importance in the sphere of medicine because from that moment onwards empirical medicine began to co-exist with another form of medicine, which was of a religious character or involved faith. These two dimensions would never disappear from human history.

2) The appearance of the Neolithic period is usually described as the moment of the agricultural revolution. Perhaps, however, it would be more correct to see this event as the result of the slow and continual development of certain primitive societies. It seems that some of these societies gradually established themselves in more fertile areas, locations which offered greater life opportunities. These societies learnt to cultivate the land and to domesticate animals, and for this reason laid the bases for a new way of transforming resources into opportunities, and as a result for a new way of generating wealth. They began a new kind of society – so-called 'agricultural society'. They were more sedentary than previous societies had been and gave rise to more populated settlements, from which cities then derived. The Neolithic revolution created an important process of urban concentration. These new cities arose in specific zones which in general were marshy and near the mouths of great rivers, such as the Indus, the Nile, the Euphrates and the Tigris. Indeed, it seems that agriculture was born in an area of the so-called 'fertile crescent' which goes from the north of the

desert of Arabia to Egypt and the Persian Gulf.

The economy of these populations was much richer than those of the societies which had preceded them and this enabled them to escape subsistence and to generate surplus wealth. This, in turn, began to be transformed into new forms of activity, giving rise to political, religious, cultural, scientific etc. institutions. This explains why great religious, architectural, literary and scientific monuments have been handed down to us from these societies. Sumer, Assyria, Babylonia, Israel, Greece, and Rome – all these were great agricultural societies and all of them produced in their own ways great cultures. Western culture was born specifically in this environment, as a result of the encounter between what were the three great cultural phenomena of that period – the religion of Israel, ancient Greek philosophy, and Roman law.

Agriculture and stock-raising were very powerful instruments in the transformation of resources into opportunities and thus in bringing about an increase in wealth. These societies then began to have better diets: they could eat a greater number of carbohydrates because of the extensive cultivation of cereals, and a greater number of animal proteins. This increase in wealth allowed them to feed a greater number of people and thus encouraged an increase in population levels which from that point on began to grow arithmetically. This did not mean, however, that periodically there were not 'subsistence crises' caused by periods of bad harvests.

Certain pathologies became more common, such as those brought about by hunting large animals. Others appeared or increased in incidence. The high consumption of carbohydrates increased the presence of certain metabolic illnesses such as diabetes. From the literary evidence that is available to us we know that health problems caused by the consumption of alcoholic drinks also increased. These drinks had been made possible by the technique of fermenting cereals. In their turn these drinks enabled these populations to control the spread of infectious diseases through water, diseases which were very frequent in the marshy areas where in general these populations settled. The pathogenic effects of water consumption led these populations to look for alternative drinks, for example fermented drinks such as wine (in the western part of the Mediterranean) or beer (in central Europe). Another system was the use of fermented water with infusions of coffer or tea, as was the case with eastern cultures.

Another novelty was the appearance of social strata which were much more marked than had been the case during the previous period. Intellectual and manual workers began to be differentiated in a very clear fashion. Another characteristic of many of these societies was the existence of a specific kind of poor person, represented paradigmatically, to begin with, by the slave, and then by the servant.

The cultural institutions of agricultural society generated a form of medicine and health care which lasted until the eighteenth century. One of its characteristics was a close relationship with religious institutions. Thus it was, for example, that in most of these cultures there was a form of medicine which was clearly priestly in character, although there was also a form of medicine which was secular or lay in profile. The first was more or less concerned with the treatment of internal illnesses and the second with external or surgical maladies. Gradually, with the passage of time, the first lost influence in favour of the second. However, it should not be forgotten that hospitals were religious institutions until the beginning of the modern world.

3) The industrial revolution constituted the point of departure for a new way, the industrial way, of transforming resources into opportunities and thus of generating wealth. A new society thus came into being, industrial society, and this society was based upon the development of the secondary economic sector.

The industrial revolution began in the middle of the eighteenth century with the substitution of human or animal power by mechanical power in industry and mining, something which led on to the ability to build heavier and more powerful machines and to install them in factories. Of essential importance in this process was the discovery by James Watt of the steam engine between 1769 and 1784, an invention which stimulated the consumption of coal and steel, the basis of the whole of the first industrial revolution. The creation of heavy industry based upon coal and steel gave rise to an improvement in communications and transport (as a result of which raw materials arrived at their place of transformation at a lower cost) and the development of many other industries, such as the textile industry.

The industrial revolution was followed by many others. There was the revolution in economics expressed by the emergence of liberal economics, the work of the Scotsman, Adam Smith. According to the ideas he proposed, the wealth of nations is fundamentally based upon labour, something which allows resources to be transformed into opportunities. The liberal economy was based upon the morality of work and savings. This was obtained through hard work, low expenditure on goods, and the investment of surplus wealth in products. In this way, that capital was accumulated which was necessary to the birth of heavy industry. In the approach of Adam Smith, this produces goods which must compete on the market with the products produced by other people. According to the fundamental law of liberal economics the market regulates supply and demand in the best way possible and always reaches the optimal point. This means that for this outlook the market is the agent which ensures that the highest quality products at the lowest cost always triumph. To intervene in the market and to impose a self-regulation was thus seen as something which was not only economically wrong but also morally reprehensible.

The appearance of new industries in the outlying areas of the cities of central Europe generated new problems and hardships. In fact, the industrial revolution gave rise to new pathologies which were specific to industrial activity. This

revolution was the cause, for example, of an increase in the incidence of tuberculosis from the middle of the eighteenth century onwards. Furthermore, it generated a great number of illnesses caused by the unhealthy conditions of the outlying areas of cities. A new kind of poor person appeared, the so-called proletarian, and new kinds of illnesses rooted in urban acute poverty, the concentration of the population in cities, and jobwork also came to the fore.

A new form of medicine also came into being. It was no accident that this revolution coincided with the appearance of so-called 'modern science'. With the increase in wealth more money was invested in universities and centres of research. Modern medicine arose at the end of the nineteenth century and developed and advanced for the whole of the next century. Medical practice, for its own part, also specialised. As George Rosen demonstrated some decades ago, specialisation could take place when an important increase in knowledge occurred and technology came into being which required specific training, and in addition when all this coincided with an increase in, and concentration of, the population, developments which allowed the full professional employment of the new specialists. This took place in the industrial cities of the nineteenth century. Lastly, health care also changed as two new phenomena came onto the historical scene. On the one hand, there was the 'medicalisation' of hospital care which meant that hospitals moved from being seen as charitable institutions to being considered centres of medical care. On the other hand, there was the birth of public health provision and public health care policy and thus a marked increase in the involvement of the state in the world of health and health care.

The increase in wealth, the improvement in health care conditions, and the advance and progress of medicine led to a major increase in population levels and to a raising of the rates of life expectancy amongst the citizens. In fact, in the middle of the eighteenth century the phenomenon known as the 'population explosion' began to make itself felt, that is to say the geometric increase in gross population figures, a phenomenon which had been unknown up to that point in the history of mankind.

4) After the First World War a new phase began – that of post-industrial or consumer society. This was brought about by the creation of a new way of transforming resources into opportunities, something which took place within the tertiary or service sector. This spectacular increase in life opportunities through the development and growth of the tertiary sector was made possible by the development of the 'second industrial revolution', which in turn was based upon the combustion engine and the exploitation of oil. This development revolutionised communications and transport and allowed the rapid movement of goods and services at prices which up to that time had been thought to be unobtainable. This increase in the service sector was not only the outcome of the private sector of the economy. It was also, and above all else, the result of state enterprise and action. The state began to grow and to be responsible for tasks which liberal theory had prohibited. From the liberal state one passed to the interventionist state which defended the life of citizens against the negative events of life – the so-called 'welfare state'.

This new stage had its own separate economic theory which was different from classical liberal theory. John Maynard Keynes introduced the concept of 'aggregate demand' in the early 1930s and asserted that it was the central feature of economic activity. In this outlook, aggregate demand includes the expenditure of consumers, private investment, and public expenditure. In Keynes's view wealth grew in proportion to aggregate demand, and for this reason it was necessary to increase it by increasing the purchasing power of consumers, lowering interest rates in order to stimulate private investments, and increasing public expenditure. As a result of this approach, consumption was held to be the engine of the economy and the producer of wealth. It was therefore thought necessary to centre every economic process around consumption and not around increasing production as had been recommended by classical theories. Keynes asserted that consumption automatically brought about an increase in production, at least in societies which had already passed through the first stage of the industrial revolution. In these societies, he thought, it was without doubt necessary to preach austerity in consumption in order to increase the investment of capital in production goods. Keynes, however, thought that in developed societies this theory was not only useless but actually damaging. This economist thought that in stimulating savings and frugality in consumption, economic development and growth were checked and the emergence of crises was encouraged. In order to avoid such realities, he argued, there was no other possibility than that of changing the mentality and the morality of the population, which had to see that consumption was positive and savings were a moral vice – avarice and miserliness. For this economic thinker, consumer society not only required a new form of economics but also a new form of morality.

Keynes argued that in order to stimulate the consumption of the population it was important for the state to protect the citizens from the negative episodes of life, from unemployment, from illness, from death, and so forth. Such were the

origins of the systems of social insurance and social security which were extended to the whole of Europe during the first half of the twentieth century. Social health care was a consequence of this new model of society. It is no accident that such a phenomenon did not exist before the twentieth century and that this model of society began to display signs of crisis in 1973 when criticisms of the social insurance system and of the health service care began to be heard.

It is important to observe, lastly, that consumer society generated a new concept of health, namely, health as a consumer good. In industrial society health was always understood as a production good, in the same way as a healthy person was a person who could work and a sick person was a person who could not work. Now, in contrary fashion, it was seen as a consumer good. The welfare state defined health in new terms and along lines which were different to those which had been adopted by previous societies. This definition identifies health with well-being. It is no accident that the World Health Organisation defined health as 'state of perfect physical, mental and social well-being and not the mere absence of illness'. The society of well-being sees health as perfect physical, mental and social well-being. In other terms, the consumption of health can be stimulated and increased indefinitely.

3. The Contemporary Situation: the Problem of the Exploitation and the Excessive Use of Resources

The Keynesian model began to be called into question in the early 1970s. The economic crisis of 1973 was seen by many people as the end of a phase. As is known, this crisis, which is also known as the oil crisis, was the first crisis of resources. Our generation was the first to have to face up to the curious and surprising phenomenon of the excessive use of natural resources. Opportunities have grown to such an extent that for the first time resources have been threatened, whose renewal in many cases will be difficult or which have a cycle of renewal which is very slow.

Hitherto it has been believed that resources were more or less inexhaustible and that in some cases they greatly exceeded the opportunities provided by their use. The classical problem of the human species had always been the same – the lack of effective procedures by which to transform resources into life opportunities. The problem, therefore, was not the resources but the procedures of transformation. Only from the early 1970s was the problem begun to be seen in a clear way. The famous report of the Club of Rome entitled 'the limits to growth', which was published in November 1971, called attention to the excessive exploitation of the resources of the planet and to the mortgage which in the medium term was being placed on the quality of life of the future generations of the inhabitants of the planet. The problem was not, as it had always previously been, one of how to find a new method by which to transform resources into life opportunities in a better or more productive way, but rather, in contrary fashion, one of measuring the process of the creation of opportunities and at the same time conserving and recycling resources.

The Keynesian approach was based upon the principle according to which wealth is the same as consumption, and as a result of which the greater the consumption the greater the estimable wealth. Now a different approach began to be adopted. Unchecked consumption was seen to lead to the deterioration of the environment and as a result to the deterioration of quality of life. Quality of life and consumption were held to be terms which were not directly inter-related. An increase in consumption could, it was held, be followed by a reduction in individual and collective quality of life. In fact, this is what was thought to be happening. The same group of researchers who produced the report 'the limits to growth' published twenty years later, in 1991, another report, this time with the title 'beyond the limits'. In their view, mankind has gone beyond the limits of growth and at the present time is immersed in a development which cannot be sustained without end and which will not be sustained for a long period of time.

Now the fundamental concept is that of 'sustainable growth'. This concept begins with the principle that both the growth of the first world and the under-development of the third world are 'unsustainable', and that it is necessary to effect a global change of policy and practice in the direction of so-called sustainable growth. This is an economic theory which is an alternative to the Keynesian approach and to that of classical liberal economics. It is also a political model. For this reason the United Nations has made it its own political philosophy. But it is much more. It is an ethical theory, and requires, without doubt, great ethical commitment. The doctrine of sustainable growth asserts that in the processes of decision-making one should not only take into account individuals, a society, or a country, but the whole of mankind, both present and future. Lastly, it is also a medical theory. In fact, the Hastings Center has been working over recent years on a project entitled 'sustainable health'.

Sustainable growth must necessarily be 'global'. Hence the importance during this new phase of development of the concept of 'globalisation'. Globalisation begins to be possible thanks to a new revolutionary fact, that phenomenon called the 'third industrial revolution', that is to say the electronic and digital revolutions which will be able to make a new world possible, a world which is more integrated and reasonable, and also more just. Here, too, it is clear that we are face to face with a new ethical challenge upon which, probably, will depend our future, the future of humanity.

This is our situation. We are living in a critical epoch in which we need new concepts both in the economic and in the political sphere, and in the moral and in the medical realms as well. Here we encounter our great challenge and also our first moral obligation.

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IV: Light in Inter-Religious Dialogue

YOSEF LAMDAN

IV.1 Judaism and Health Care

It was the English poet, Alexander Pope, who wrote "... fools rush in where angels fear to tread". I greatly appreciated the invitation to address this International Conference. But, to tell you the truth, I am not at all sure of the wisdom of my accepting it.

After all, this is a highly professional conference of health care specialists of one kind and another. I, on the other hand, am a career diplomat, prepared as Queen Elizabeth I of England quaintly put it "to lye abroad", and to put my own health at risk by going to endless official receptions, cocktails and dinners. But there is nothing in my training which has equipped me to speak authoritatively on Judaism, Health Care and Society. Understand therefore my apprehensions.

With your permission, I shall divide my remarks into three parts:

1) Some general observations about Judaism and health care;

2) Some Jewish principles in contemporary Applied Health Care Ethics;

3) Some illustrations regarding care of the aging.

In all of these areas, I am greatly indebted to Jewish scholars whose works I have consulted.* I hope that I will represent them accurately, but if I slip up, the errors and responsibility are entirely mine (and forebearance is yours!).

1. General Remarks

It is no great revelation to observe that in Biblical times, religion and medicine went hand in hand, as they did in so many other ancient cultures. But for the Israelites, there was a fundamental theological rationale for this, summed up in Ezekiel's famous phrase (addressed to God): "The spirit is yours and the body is yours". In other words, God creates and controls everything in man's being, both spiritual and physical.

In the Temple period, the priests, in addition to their ritual duties, were custodians of public health and ministers of health care (even if these terms would have been totally foreign to them). From Talmudic times to the Middle Ages, physicians were very often Rabbinical scholars. That is to say, a tight nexus remained between Rabbinical learning, reflecting a devotion to God, and medical science reflecting a devotion to the wellbeing of man created in the image of God.

This Jewish involvement in medicine required a conceptual framework – in our case, a religious one – from very early on. The well-known debate over the propriety of human intervention in sickness and physical suffering, perhaps against God's will, barely arose. There are numerous references in the Old Testament to God as a healer: "I am the Lord that healeth thee" (Ex. 15:26). Priests and later medical practitioners were the instrument through whom God could effect the cure: "He (man) shall surely heal" (Ex. 21:19).

This was not merely a "license to cure", as it were, but a divine commandment, obliging physicians to treat the sick without discrimination.

As instruments, or messengers of God, the highest moral standards were demanded of Jewish doctors, especially in their operative guidelines. And in Jewish medical ethics, two principles, highly relevant to your conference, reign supreme – first, the obligation to preserve human life, which is God-given and sacrosanct; and, second, the obligation to offer medical treatment and health care to all. In Jewish thinking, both of these religious imperatives are anchored in no less a framework than the "Ten Commandments".

"Thou shall not kill" is rendered positively as an injunction to preserve human life at all costs. To illustrate its overriding importance, the Talmud rules that saving human life takes precedence over the Holy Sabbath (Yoma, 85 A). And how do you "Honour your father and your mother", especially in their advanced years, if not by offering health care, among other things. Again, the Talmud holds that in order to treat the elderly and the sick at large, the sanctity of the Sabbath can be set aside, even if the situation is not completely life-threatening.

If one looks at the 613 commandments in the Pentateuch, one finds an extraordinary emphasis on social medicine and public hygiene and on what would be regarded today as aspects of health care in general.

Indeed, as many as 213 of the 613 Biblical injunctions are of a medical or quasi-medical nature, setting out strict dietary requirements, regulations for personal and public hygiene, rules for the prevention of epidemics, isolation, quarantine, etc. These Old Testament standards are remarkable even for today.

However, it was not until the 12th century that a certain concept of "Health Care and Society" was articulated by Maimonides, the great Rabbinical scholar, philosopher and physician to the Court of the Sultan of Egypt. It was he who divided medicine in three broad categories:

1. Care of the healthy;
2. Curing of the sick;
3. Treatment of the convalescent, including the aged.

Starting in 14th century Spain, Jews often offered informal health care and support within their own society through voluntary associations for "Bikur Holim" (visiting the sick), which also was regarded as a religious duty. In many European communities, Jewish hospitals and independent health services were set up in the 18th century, frequently due to lack of access to non-Jewish ones. In other words, Jewish health care systems emerged, in part, as a function of their historical and social circumstances. At all times, however, they were administered within the framework of Jewish religious law (the "Halachah"), based on a deep understanding and sometimes far-reaching interpretations of the Old Testament (the Torah).

2. Some Principles in Applied Health Care Ethics

Allow me now to make the leap to modern times and briefly address some contemporary health care issues (from the orthodox Jewish perspective).

a) Seeking care.

In present-day society, one tends to think of health care in terms of giving. However, in Judaism, the sick are morally obliged to actively seek medical attention and health care. From our religious point of view, man is given his body as a trust from the Creator to use and to carry out His will. Man has no mandate to harm it or abuse it. Quite the opposite, man is required to preserve his body and health as best as he can and to seek out professional help and care for the purpose.

Conversely, no one has the right to refuse health care. Putting religious observance above medical treatment is not regarded as an act of piety, but the reverse. Thus, it is not to be tolerated.

b) Health care decisions and autonomy.

The Jewish model for decision-making in medicine is based on a triad. First, the physician (who is obliged to treat the patient and offer the best available medical advice); second, the rabbi (required to address ethical questions and medical problems relating to religious law); and, third, the patient himself. The latter has the independence to choose his medical and rabbinical advisers, to whom he then abdicates a great measure of his autonomy, while remaining free to decide mainly on non-medical and non-ethical/legal matters.

The assumption is that, through this dynamic triad, with each person pronouncing on his own area, optimal decisions will be reached to complex medical and ethical issues, judged on their own merits and according to their specific circumstances. From a philosophical point of view, the model requires the patient to make a free choice to waive much of his decision-making power to others, in line with his voluntary acceptance of the Torah and the Halachah. In effect, observant Jews make a conscious choice to limit the scope of their autonomy in medical matters to rather narrow areas, which can be deemed "neutral", both morally and religiously.

For example:

I. If there are several equally effective medical options and one option is preferred for non-medical reasons (eg. financial or cosmetic considerations), the patient has the choice to refuse that option.

II. A patient may decline a treatment which entails great suffering or has significant complications, if other options exist.

c) When principles clash.

In general, Judaism is opposed to "absolutizing" any single religious principle or ethical precept (beyond giving supremacy to the preservation of human life). Wherever possible, a middle path or 99 "golden mean" is advocated. Hence, principles compete, as it were, for priority, and when conflicting medical values are encountered, each case, each patient, must be considered individually and decisions reached on the specific clinical and ethical/legal circumstances, within the framework of the Halachah.

d) Beneficence.

To benefit a fellow man (or woman) is a moral and religious imperative in Judaism, based on several Biblical injunctions.

In the patient-physician relationship, the notion of beneficence is strongly emphasised in the positive commandment to physicians to treat and assist every patient, without discrimination. The patient-physician relationship is in fact regarded as a quasi-religious covenant, based on beneficence, rather than a civil contract, based on mutual agreement.

e) Non-maleficence.

Harm and injury to body and soul are defined very widely in Judaism, and the avoidance of maleficence is a positive duty within the broad category of religious injunctions governing relations between man and man.

In medical and health care situations, the clear obligation placed on a physician is never to use his knowledge to harm or injure someone. Health care professionals are required to be experts and keep up with the highest standards of knowledge and skills in order to avoid, or at least minimize, any potential damage to a patient, resulting from necessary medical intervention.

From the Jewish perspective, non-maleficence also includes causing bodily harm or damage to one's self. As already mentioned, every individual is commanded to watch over his own life and health and thus is enjoined against any form of self-harm, injury and suicide.

3. Judaism and Aging

The treatment of the Jewish elderly and the health care offered to them is of course bound by the religious and moral framework I have just sketched.

In the Old Testament, ages were recorded with some fascination and

in detail. In the Talmud, the "ages of man" are vividly defined (60 is elderly and 70 is distinctly old) and there are elaborate discussions of factors which bring on old age, in addition to the passing of the years. There are physiological and sociological descriptions of elderliness, and broadly speaking, old age is clearly seen to be a varying physical condition, not simply tied to chronological age.

There is, however, one constant: the proper attitude to advanced years – respect and honour. "Rise before white hair and give honour to the old" (Lev. 19:32). That constant, that fundamental respect, is to be extended to all the elderly, no matter their religion, status and moral worth – and it requires that their health needs be looked after, thoroughly and with compassion.

Like charity, health care of the aged begins at home. On the basis of the Old Testament, children are enjoined to look after all aspects of their parents' well-being "until the Lord has mercy on them". If the child cannot care for his parents at home, he is required to find a suitable alternative – giving a clear basis in Judaism for the provision of old age homes and assisted living. A child is forbidden to go against the wishes or demands of his parents and hence, in various circumstances, he is obliged to entrust their care to physicians and health care professionals. There is no question of children trying to treat the ailments which afflict the elderly by themselves, on the grounds of honouring their father and mother.

Now let me try to outline some Jewish positions on various predicaments often encountered in dealing with the elderly (but not only them).

a) Information giving

Frequently, modern approaches to this question suggest that the sick must be fully informed of their conditions, no matter how grave. Judaism takes the position that neither the doctor nor the family can make any final medical decision so long as the patient himself is capable of being involved. Thus, information giving is called for. However, in the case of terminal patients, the Halachah imposes certain limits on what information can be given, primarily to prevent mental anguish and psychological stress which may aggravate the patient's already grave condition and possibly shorten his life. Moreover, any information offered in such a situation must be given in a way which does not cause the patient to lose all hope or compromise his will to live. According to certain authorities, it is absolutely forbidden to inform a terminal patient how long he may be expected to live – even if a lie has to be told. One must continue to feed and tend for the terminally ill, and placebos are to be administrated if all other medication would be futile.

b) Relieving pain

Unlike some other religions, Judaism does not regard pain in illness as a punishment to be endured. For us, pain is a kind of moral and medical challenge to be grappled with. The Lord is to be served in joy and not in agony; ongoing pain and suffering are regarded as worse than death. Hence, so long as a medication helps relieve pain, especially for the aged, it is to be utilized – even if it may have some life-threatening side effects.

c) Preservation of life, as against quality of living

For Judaism, this is virtually a "non-issue". Life, being God-given, is to be preserved and prolonged almost at all costs. The value of any life cannot be measured in terms of quality, based on comparative or relative factors, often reflecting transitory social norms. Since life is holy, man has no authority to shorten it for the sake of the quality of living.

Hence, in Israel there is no arbitrary cut-off age for receiving intensive care. Old age homes and facilities are required to have equipment for resuscitation of patients, including those in advanced states of dementia. In the attempt to preserve life, aggressive procedures such as naso-gastric tube feeding are administered to those in need thereof. In the case of certain terminal patients, the use of powerful medications may be relaxed, while the obligation remains to feed and care for these patients as long as medically possible.

d) Euthanasia

In the light of everything said, it will be clear that in Judaism any form of *active* euthanasia is strictly prohibited. This is in fact regarded as plain murder, with all that that implies from a religious and ethical/legal point of view.

However, Judaism does make a distinction between medications, treatments and equipment designed to *prolong life*, as against those which aim to *delay death*. It is far beyond my competence to define the sometimes narrow line between the two, but I do understand that, when death is imminent, the Halachah is prepared to sanction, perhaps even require, the withdrawal of any factor, whether extraneous to the patient or not, which may artificially delay his demise in the final stage. (In making this statement, I have drawn directly form *Jewish Medical Ethics*, pp. 123-124, by Rabbi Dr. Emmanuel Jakobovits, the former Chief Rabbi of the United Kingdom).

This issue, and several others I have touched upon, are profoundly complex and being unqualified in these matters, I shall go no further. I only hope that having been so bold to venture thus far, I have been able to convey some insights to Jewish attitudes and approaches to Health Care and Society. For the rest, you must turn to specialists!

H.E. Mr. YOSEF LAMDAN
Ambassador of Israel to the Holy See

Notes

* I am particularly endebted to Professor Abraham Steinberg, author of the standard Encyclopedia of Jewish Medicine (in Hebrew) who consented to my free use of his material.

I am also grateful to Dr. Aharon Cohen, Head of the Geriatric Division in the Israeli Ministry of Health, who sent me a wide selection of materials on aging, including a lecture (on tape) by Chief Rabbi Israel Meir Lau; and also to Rabbi Yaakov Weiner, Head of the Jerusalem College for Research, who spent valuable time with me.

Of the printed works consulted, I would especially mention:

1. JAKOBOVITS, IMMANUEL, *Jewish Medical Ethics* (New York, 1975).

2. SHULMAN, NISSON E, *Jewish Answers to Medical Ethics Questions* (New Jersey and Jerusalem, 1998).

3. Weiner, Yaakov, *Ye Shall Surely Heal* (Jerusalem, 1995).

4. *Encyclopedia Judaica* (Jerusalem, 1972, 12 vols.) - several authoritative articles.

For the serious searcher, the Internet is replete with material (of mixed quality) on the topic at hand.

MAURICE BORRMANS

IV.2 A Light in the Inter-Religious Christian-Islam Dialogue: the Virtue of Compassion

Two years ago I was able to describe the importance of the support given to serving the cause of health and sick people in Muslim societies – classical Islamic civilisation, like the civilisations which preceded it and followed it, made its own contribution to medical science. In its own way it also took care of sick people. The modern states where Islam is the official or unofficial religion, faithful to this centuries-old tradition, have thus developed – imitating the health care systems of Western countries – a set of institutions and structures in order to guarantee to all their citizens access to preventive and curative medicine.

A year ago, speaking from within the same perspective, I recalled the privileged place that elderly people have in the popular mentality and in public opinion in these Muslim societies. Times have certainly changed and these people often run the risk of being marginalised, as indeed is often the case in Western societies. It is still true that 'elderly people' in the Muslim context still have the right to be respected by everybody, if not to receive the care of the whole of the community. Euthanasia is not yet a problem for Islamic societies – life remains an essential value, from conception to death, even if the *Sharia (*Islamic religious law) authorises the death penalty in three specific situations (talion, adultery, and apostasy).

But in the world of health and society, amongst the needs of the individual and the care provided by the community, there is suffering and pain, and these are inescapable human experiences which sick people experience or are subjected to, and which medical doctors and male and female nurses accompany. At the cross-roads of health and society, there is thus to be found human suffering where Christians and Muslims no doubt have much to share, even though the former cannot make the latter understand the redemptive value of every example of suffering lived out in union with the suffering of the crucified Christ. At the least they can help them to give to their suffering a profoundly religious value where faith manages to express itself, leaving a secret space to the work of the Holy Spirit. It is in this perspective of accompanying and mutual exchange that I would like to invite you to reflect upon the values of compassion that all sincere believers can live out together, with words or in silence.

To this end, it seemed to me that the best thing to do would be to recall with you the posthumous message of Soumia Lamri, a young Algerian woman who was ill with cancer and who died recently at the age of seventeen and a half in Ain Sefra (Algeria) after years of great suffering, and accompanied by a priest, a friend of mine. The texts written by Soumia in her own hand and left to her family, the Soumias, can inspire us in our reflections and thoughts. Certain observations made by the priest who went to visit her almost every day are for us an invitation to act to ensure that every hospital becomes a holy temple of a merciful compassion in which Christians and Muslims say many things to each other under the gaze of God. Many lights can shine in the sky, which is at times cloudy, of Islamic-Christian relations!

The Posthumous Message of Soumia Lamri

Soumia Lamri was a young high-school student in Ain Sefra (Algeria). She was born on 23 July 1981 and died on 25 March 1999 after struggling for a number of years against bone cancer. Despite three surgical operations the disease spread throughout the body. From December 1998 we accompanied her first in her home and then in the obstetric wards of the hospital until her end... with tenderness.

Here are two documents left behind by Soumia and which we entrusted to her mother eight days after the burial. We have here a school exercise book in which she wrote three poems which were written after she had been discharged from the hospital of Mecheria after knowing that she had been condemned... and a letter which was written to her by the surgeon of Mecheria who had operated on her. I have translated these documents from Arabic into Italian.

These texts are worthy of note because of the authenticity conferred on them by nearness to death and the deep faith which underlies them. They are precious examples of witness to the approach and attitude of a real believer in the face of suffering and death.

Here, first of all, is the letter written by the medical doctor to Soumia: 'In the name of God, the All Merciful, the Merciful, To Soumia, my poor daughter, do you despair of the mercy of God? Everything that comes from God is mercy, even though it is illness and suffering. We do not see nor do we know the root of things and what the Creator wants. Praise God for the fact that He has brought a remedy for every malady. What you have learnt in your trials others have taken many years of their existence to understand. 'It is possible that you do not love anything, but this for you is good'. Try, therefore, to find usefulness in your suffering. Because in your suffering there is mercy and you will find the wisdom of God, patience, and healing, if God so wants'. My greetings, your physician!'

The absence of a date means that we do not know if the letter by this medical doctor came before or after the composition of the poems. It is of little importance! What is certain is that this letter is an answer to a message of the sick girl (who for that matter confirmed the fact). If the medical doctor thought he could be so direct this is because between them there was friendship and trust, and he knew the qualities of the soul of the person he was writing to... His letter seems to have made a great impression on this adolescent girl, as is borne out by the tears on the paper.

This letter joins conciseness with great elevation of the soul. In it God is omnipresent (He is referred to seven times). It refers us constantly to His mercy (five times), to His omniscience and to His providence: 'to every malady He brings a remedy' (*Yadith* from the *al-Bukhari* or *kitab al-ibb*). We, instead, poor humans, do not see or know the root of things, and hate illness and suffering, whereas 'for you it is a good' (The Koran 2:216). It is an appeal, without any concession, to a vision of naked faith about suffering, which has its own usefulness and enables us to enter the wisdom of God.

This is a sharp and direct message which could not but provoke tears... fertile tears, as is borne out by the little school exercise book. Most Algerian adolescent girls have a school exercise book or an album in which they keep documents, photographs, letters, texts, and all the rest. Soumania was no exception, and in beginning this school exercise book she made clear, after the *bismillah*, that she was doing this to write down her poems, to express her thoughts, and also to conserve her memories.

Here is Soumia's first poem:

In the name of God, the All Merciful, the Merciful,

In the name of the first Cause of everything, of the Inspirer of poetry, of He who speaks to friends, I, Soumia Lamri, write for the first time with a blue pen on a white sheet, to give free expression to my feelings and to record my thoughts. The first idea is:

'What comes into my mind' or 'Time'

You do not know what it conceals, nor what it proposes,

but the bitterness of time suddenly falls on you.

There are jealous people, generous people, the bearers of gifts, there are unjust people.

However, time changes neither my destiny nor my days, and does not reduce my pain.

Ah! O Time!

Time for me was constant, a painful devastation.

It has made me lose every description of my trials,

it has led me to the heights of my pain and my suffering.

Time has changed my appearance and dispersed my knowledge.

It has made me lose my beauty and youth. Ah! Time, you have betrayed me.

What was sweet for me you have made bitter; my adolescence has been handed over to medicine.

O time, amazing, extraordinary, you who darken family and friends.

You in whom the innocent sick person is wounded and the proud oppressor is praised.

O time during which the brother becomes an enemy because of the burden, and the child becomes unjust for his father.

Ah! O Time!

Time who plays with the nations.

You who break up a family and bring the end of children, the seed of pain and suffering.

If it is true that you reap what you have sown, may it please God, O time, that you go back on your paces,

And that you make me forget what has happened to me.

This first piece is a long rather than desperate reflection on the passing of time. 'Time passes, the days go by...' It is a reflection which evokes certain emphases to be found in Wisdom or Job in the Bible. Time is referred to sixteen times. It is the deceiver, the betrayer whose bitterness falls on you all of a sudden. It is the seed of pain, of suffering, of bitterness, and of trial (ten times). It neither changes destiny nor reduces pain... You have made me lose beauty and youth... My adolescence passes in the hands of medical doctors... One has to flee from relatives and friends (she complained of the fact that most of her school companions had left her)... Few references to faith and God, but a passage which refers to 'destiny', the invocation of the beginning: 'in the name of the first Cause of everything and the Inspirer...' (references to the Koran) and the final wish and hope: 'may it please God, O time, that you go back on your paces, And that you make me forget what has happened to me'. It is probable that this poem was written before the shock created by the letter from the surgeon.

Here is the second poem by Soumia:

'How difficult are the moments that I live'

Ah! A thousand sighs that come from my pain, my pain that has pity neither for my heart nor for my heart.

A pain that was decreed for me, in the book of my destiny.

A pain that is not like the ardent desires of my heart, nor like the torment of my body.

A pain that has thrown my reason into amazement and turned my arteries into embers.

Oh this painful suffering, how much it has made me suffer and forbidden sleep to my body!

Suffering in my heart and in my intelligence, suffering in the deepest part of my profundity.

Suffering that no medical doctor heals, and which time does not reduce.

My pain does not come from a desperate love, nor from a passion, but from the Lord of the worlds.

An illness was decreed for me, in it for me there is no hope.

An illness has seated itself in my soul, my foot withdraws from my movement.

An illness which has made me lose the breath of youth, and has killed within me all my dreams.

My dreams as a girl, dreams of quiet and tranquillity.

An illness which frightens me during the day and obsesses my nights with the torments of tomorrow.

Will there perhaps be a healing, Lord, a healing which comes from You, for me and for all my brothers and sisters?

You, Lord, are our Shepherd,

our Benefactor, He who makes us live and die, Lord.

Lord, answer my prayer, and the prayers of all my brothers and sisters.

O Lord of the worlds, O Creator of the whole Creation.

This second poem is dominated by illness (cited four times): an illness decreed in her destiny (three times), an illness without hope, which neither time nor a medical doctor can heal. An illness 'seated' in her soul and which frightens her day and night. It has made her lose her youth and all her dreams as a girl. This text lays emphasis on the consequences of the illness, which are pain, suffering, and trial (*waja'* seven times, *alam* five times). Physical pain in her body, moral suffering in her heart, in her reason, in her intelligence... in the deepest part of her profundity!

Differently from the first poem, this second poem refers to God quite often (eight times) and on different occasions with phrases from the Koran: 'Lord of the worlds', 'Creator of the whole Creation'. In another passage God is called 'our Shepherd and our Benefactor'. This text twice evokes the prayer of the heart (*du'a*) and thus sees the faith and placing oneself in God's hands as the only way out. It is not therefore without hope, and healing is seen as the last hope (four times). 'Will there perhaps be healing, Lord, a healing which comes from You'... It is you who make live and die (this is another allusion to the Koran). Answer my prayer!'

Was this poem written after receiving the letter from the surgeon? Whatever the case may be, it reflects the spread of the illness, the increase in suffering, and a certain psychological evolution in relation to her own malady.

This is the third poem by Soumia:

'The Faint Light of my Hope'

Ask the set of times, they will speak to you about my pain.

Ask all men about my suffering and my trial.

I am ill and bear my pain, but in all ways I am strong.

God has given me enough faith.

I am not afraid of my fate, but of the trials of my path.

My song is my prayer, O Lord, my healing.

I say and say again, in my loudest voice: "You are welcome, O death!"

I am not afraid of you, but of meeting my Lord.

This third and last poem, whose rough copy bears the line 'my suffering and my tribulation' bears the title in her school exercise book of 'the feeble light of my hope'. This was the last title wanted by Soumia, and indeed best reflects the character of the contents. Indeed, if illness, pain and suffering are still present, they are no longer present in a dominant way, in the form of a leitmotiv, as is the case in the other poems. She upholds, on the contrary, her own soul: 'I am ill and bear my pain, but I am strong'. She prays: 'O Lord, my healing'. Finally, she says and says again that she is not afraid of her fate or of death – death which now stares her in the face: 'You are welcome O death! I am not afraid of you'. She is afraid only of her encounter with her Lord, who will judge her.

What a magnificent unfolding and development! The disenchanted reflections, almost desperate in character, of the first texts, are followed by faith, courage and lucidity. In these lines she starts on her way to her meeting with her Lord. An observation was often made after her death: 'God purifies, through suffering, those that He loves in a special way' (*Yadith* from *al-Bukhari* to the *kitab al maral*). Her young sisters, nine and eleven years old, know her poems by heart and used to recite them on my shoulders, as they gradually discovered them in her school exercise book.

The impact of the long weeks of suffering and courage of Soumia was very great for all those – relatives, friends and hospital staff and personnel – who accompanied her until the end. Everybody remembers her pained smile during the course of her trial, and of her radiant faith. May these poems which she left behind her help others to face up to and to tackle life with greater courage, because it is those who are about to die who teach us how to live.

An Added Note on Compassion as the First Word of a Muslim-Christian Dialogue by Francois Cominardi

1. On the Track of Pierre Claverie and Christian Chessel

Observing the failure of a large number of attempts at inter-religious dialogue, Pierre Claverie declared: 'We have a shared vocabulary, but the meaning of the words is different. We must take everything from bottom up, and live together, not only in words and books, but in the words lived out together, in the right words, a shared experience...'[1]

Beginning with this observation and the shared experience of suffering that Christians and Muslims in an Algeria in crisis are now living, Christian Chessel asked himself whether 'compassion is not the first word of a discourse and the first

gesture of a commitment with another person and for another person, whatever his or her faith may be'.[2] When speaking about compassion, Christian had in mind above all else that compassion which the Chris-

tians who have chosen to remain in Algeria since 1992 experience as they share the trials and tribulations of the Algerian people, a decision taken despite their lack of security, their precariousness, their poverty, etc., and indeed often with their lives in serious danger.[3]

2. At the School of the Sick

Personally, it was at the end of accompanying Soumia Lamri, a young sick woman who was seventeen years old, that I connected living at the bedside of sick people with the reflection on compassion which was begun by Christian. This accompanying was effected with constant contact with the family and the medical team. This was a daily contact, and rather wounding for those who for over three months surrounded the young Soumia with tenderness.

At the end of this shared experience, lived as a Christian with my Muslim friends, the emptiness left by the death of Soumia and a special grace which I owe to her produced the 'impetus', that is to say that 'shared experience', 'that first act of commitment with the other person and for the other person' that I experience at the bedside of sick people, especially at the bedside of those who no longer have any hopes of getting better. It is therefore the sick people who lead me to follow in the breach opened up by Soumia, not at the educated and cultured level of an expert on Islam or on the Bible (which I am not), but at a simple basic level, as a man in fraternal contact with his Muslim 'brothers and sisters'.

3. What is Compassion?

I have consulted the dictionaries. The *Petit Robert* defines 'compassion' as a 'feeling which leads one to experience and share the negative experiences of others'. It refers to concepts such as compassion, mercy, pity, and consolation. The *Petit Larousse*, for its part, defines 'compassion' as a 'feeling of pity which makes us sensitive to the negative experiences of other people'.

The Bible, as Christian makes clear in a detailed fashion, speaks about mercy, consolation, and tenderness. This message culminates in the parable of the Good Samaritan (Lk 10:30-37) who was 'moved by compassion' for the unfortunate man who was lying at the side of the road 'half dead'. His tenderness drew him near, or better made a neighbour of him, in relation to the poor man who had been come across. Is it an accident that Jesus puts on the scene a 'half dead sick man'? I do not think so. In the Koran we find as a leitmotiv the *bismillah al-Rayman al-Rayim*, 'in the name of God, the All Merciful, the Merciful'. I would like the listener to refer here to Christian who has explained this point very well.

Compassion, therefore, is a part of 'a vocabulary which belongs to Christians and Muslims alike'. One is not dealing here solely with passive compassion, through which we are moved by another person, but above all else with active compassion, that compassion which pre-supposes a commitment to the other person. As St. John said: 'We do not love with words or language, but with facts and in truth' (1 Jn 3:18).

4. Compassion towards a Sick Person

To express one's own compassion in the presence of a sick person means to share everything with the person who suffers. It means suffering with him, putting oneself in his position, suffering with his suffering, entering into his suffering personality, making oneself draw near to him to the point of being at one with him, in order to live out his suffering. For this reason, there is no need for words: it is enough to be there, to be with him, to hold his hand, to dry his forehead, to be for him a sign of the tenderness of God.

A sign is more easily understood than words, especially if it comes from the depths of the heart... It directly reaches the heart of the other person: it is a dialogue between hearts... a level which is not entrapped by words.

When one accompanies a person who is at the terminal stage, and above all if he knows that he is condemned to die, this dialogue is destined to succeed because it is born amongst people who are aligned at the level of the essential by the nearness of imminent death – that level of life and death. People in this situation are after a certain fashion forced to rid themselves of all accessories... Naked we left the breast of our mothers, naked we will return to God. This is remembered by the person, without any words, by the person who prepares to appear before his own Creator. He places at the same level all those who take part in this experience of compassion. The dialogue which is established enables them to engage in a very deep level of communication which goes beyond words... All the reserve, all the obstacles, are removed... The way is open. This accompanying, which can only be done where there is a team, also places all those who take part in it in great harmony with each other, to the point that a single word, a single name, is enough subsequently to evoke this 'state of grace'.

5. When a Young Sick Woman Troubles Muslims and Christians after her Death

Soumia Lamri has left us three poems written after knowing that she was condemned, in addition to a letter which she sent to the surgeon who had operated on her. These documents were entrusted to her mother eight days after the funeral. The texts are worthy of note because of the authenticity bestowed

on them by the nearness of death and the deep faith which underlies them. All those who have come into contact with these letters – relatives, friends, acquaintances, members of the health care staff and personnel, and helpers – have been touched very deeply by them.

Many people have seen in them a real instrument for Muslim-Christian dialogue. A dialogue manifested on the Muslim side by the trust shown towards me as a Christian by the health care team which asked me to take part in this accompanying, and by a mother who entrusted me with these valuable documents so that they could bring light and courage to other people. A dialogue manifested on the Christian side by my absolute respect for the beliefs and convictions of Soumia and by the emotional welcoming of the thirty delegates of the diocese of Laghouat who had come together in Ghardia for the Ascension and who were able to touch with their hands this posthumous message, the incontestable action of the Spirit in the heart of Soumia and the heart of her medical doctor.

Given the demand which existed, it was necessary to reproduce this dossier and circulate photocopies of it. This dossier has provoked, in addition to emotions and tears, reflections and private communications, in both oral and written form, resolutions to be committed to sick people, and in certain cases a real psychotherapy which has brought out painful things about which it had not been previously possible to talk. It is clearly the case that Soumia has not stopped bringing about little 'miracles'.

6. They Discover that they are 'Believers'

In provoking compassion in Muslims and Christians alike, Soumia has greatly helped to change the way in which these two groups see each other. Christian de Chergé experienced this shock when an Algerian land warden, who was a friend of his, risked his life and died because he protected him.[4] This 'shock' is something I owe to Soumia, and I am not the only one.

As Christian Chessel realised, compassion is the language of the hearts of Christians and Muslims who – in a shared experience of God and man, well beyond words – discover that they are 'believers'.

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Notes

[1] 'Forum des communautés chrétiennes à Angers. Pentecoste 1994'. Cf. *La Croix*, 25 May 1994.

[2] Cf. 'La compassion, premier mot d'un langage islamo-chrétien pour temps de crise', in *Riba al-Salam,* n. 21.

[3] Christian and his three brothers – White Fathers – experienced this compassion to the point of giving their own lives on 27 December 1994. Cf. Duvan Armand, *C'était une longue fidélité (à l'Algerie et au Ruanda*) (Paris, Médiaspaul ed., 1998).

[4] Cf. MARIE-CHRISTINE RAY, *Christian de Chergé, prieur de Tibhirine* (Paris, Bayard-Centurion, 1998), pp. 47-8.

ELENA DE ROSSI FILIBECK

IV.3 Hinduism

In the introduction to *Strofe del Samhkya* or *Smhkyakarika* by *Isvarakrsna Isvara*, Prof. Raniero Gnoli observes how there are some ideas in the history of mankind which become a nucleus towards which the tendency of a whole culture moves. The distinction between matter and form has performed such a role in the West. The dual idea of *prakrti* and *purusa* has done the same in Indian civilisation. The first term refers to a sort of *natura naturans*, the manifestation of being to be found in every thing; the second expresses the idea of man/soul.

'This idea', he adds, 'which over time has animated the whole of Indian thought can be found adumbrated in certain *Upanisad,* we can read it in the *Purana*, and we also find it in most of Indian mysticism.

Everywhere, that is to say, where we find manifested the need for a reflection on the world we encounter the distinction of these two fundamental concepts'.

What is Meant by Hinduism

This quotation enables us to understand how certain philosophical concepts, born in the Vedic world, then elaborated in Brahminism, and which then converged in Buddhism, are present and traceable in the millenarian history of Indian thought, albeit in a very large number of reflections and solutions, and this fact confers upon such thought a line of continuity and a specific character.

This specific character can also be found in the religious practices of the Hindus which constitute not only the most forceful aspect of the religiosity of India but also the most important. This is because such practices ensure the creation of a sort of ideal unity of all Hindus independently of their membership of this or that school of the various Indian doctrines.

It was the *Sampradaya*, literally the conferers, who formulated over time the various doctrines. They did this by returning through their own personal experience to the facts of tradition.

At the highest level this involved sacred knowledge, or rather speculation on the concept of *Brahman* or the absolute, the ancient impersonal power connected with rites, rising then to the physiognomy of one/all

and coinciding with the inner being of man or a*tman.*

From the various schools there arose the phenomenon of the *yogin (*or renouncers), the *sadhu* (or the good), and the *varaigin* (or those who practice detachment).

Their life example, directed towards living to the utmost the teachings that they had received, was the soul of Indian spirituality.

For everybody, however, it was incumbent to put into practice the principles of the Hindu *dharma* which was based upon two fundamental elements. On the one hand the elements of *ahimsa* (non-violence) and *satya* (or truthfulness), and on the other the *svadhana*, or the specific duty of each caste.

By Hinduism we mean the traditional religious culture of India, whose territory, we may remember, was divided into the two states of the Indian Union and Pakistan in 1947 on the basis of a religious criterion, with the allocation of the areas with an Islamic majority to Pakistan and those with a Hindu majority to India, where, indeed, the overwhelming majority of Hindus now live.

We should remember that the term 'Hindu' has geographical origins. It comes from the Iranian form 'Sindh' and is thus handed down to us through the Muslims. At the time of the Islamic conquest the invaders applied it to all those who did not accept the religion of the Prophet.

In reality, the term is inversely exclusive in the sense that for a person to be considered a Hindu it is necessary for him or her to belong to a caste, and a person does not belong to a caste unless he has been born in India. The disappointment of many Westerners who, attracted by Hinduism, subsequently realised that in India no traditional community could welcome them in their midst, is more than well known.

There is thus a strong impulse to identify Hinduism with the Indian world.

Even today India is called by its educated members *tapobhumi* or the land of asceticism. In this sense one can talk of Hinduism within Indian civilisation as constituting a *continuum* – despite the coming and going of events and peoples over thousands of years – in a territory in which the multiplicity of races seems still today to create unbridgeable differences and where during the course of time different religions, ranging from Christianity to Islam, and from Mithraism to Parseeism, have spread throughout the population.

Medical Science

Medicine is certainly an expression of the cultural context of Hinduism. Since very ancient times it has been considered a science to be placed on the same level as grammar, mathematics, and astrology.

The tradition called *Ayurveda* is the basis of the teachings of Indian medicine. This tradition has connections with the *Veda,* that is to say the corpus of the most ancient texts in India of a religious and ritual character. They are in their present form thanks to the result of a process of centuries-old development and re-elaboration.

Indeed, the *Ayurveda* or science of longevity is considered at times as a secondary (*upanga*) part of the *Atharvaveda* and at times as a secondary *Veda* or *(upaveda*) of the *Rgveda.*

The *Atharvaveda* is a collection of hymns (made up of twenty books with 731 hymns and prose) containing spells, blessings, curses, songs for ceremonies and so forth. In this collection there are also theological and cosmogonic observations and reflections.

From studies conducted on the language and the contents of the hymns it has been possible to establish that the *Atharvaveda* was composed after the *Rgveda*, whose dating goes back to 1500-1000 BC. This last is considered the oldest collection of the *Veda* (it contains hymns, magical formulas, spells to heal people of illnesses and to obtain a long life etc. in ten books or cycles containing 1017 hymns).

To refer to the ancient world of the *Veda* means to refer to those concepts such as *Brahman*, *atman*, *samsara*, and *karman* which are an integral part of Indian philosophical thought and which concern the fundamental principles on which the various Indian doctrines are based in their analysis of the spiritual and material world.

The links of the A*yurveda* with the Vedic substratum have been well established. For example, in the idea that the body and the spirit are realities which penetrate each other.

The importance of medicine in the Brahmin context was determined above all else by the wish to acquire material and spiritual immortality.

Health and a long life – which had to last at least a hundred years – were a condition which was required not only because of the material advantages involved but also because of the future life ahead – good health was seen as being essential in order to perform the duties of this life and the duties of religious practices. The disciplines of yoga – Tantrism – and the study of

alchemy developed the idea of an imperishable *soma*: health and longevity were seen as the means by which to transcend the transmigratory condition, and to obtain final immortality or the uniting of oneself with the absolute.

This aspiration was determined by the belief in the constant flow of births and deaths, the chain of successive existences or *samsara,* moved by the *karman*, an iron law of causality applied to morality.

This generated the idea of a certain automatism of good and bad as a result of which, in Indian thought, man had only the hope of escaping them by achieving through various techniques and various methods a higher world where his individuality would finally be able to be dispersed (*moksa*).

Ayurveda: Texts and Tradition

Ayurvedic science has come down to us through an abundant Sanskrit literature. It should be remembered that in India Hindi, the official language of the Indian Union, is the contemporary point of arrival of a long tradition which comes from dialects spoken by the Aryan invaders of India, dialects which we call ancient Indian and of which Sanskrit, or ancient Indian *par excellence,* is one. Sanskrit is known to us from the second millennium BC from the most ancient hymns of the *Rgveda.*

Over time this language crystallised and has remained the same from the third century BC to our times, becoming the language used for literature for the longest period of time. But it is not only the great age and the continuity of Sanskrit which have made this Indian language the most important but also the fact that thanks to the greater conformity of the various Indian civilisations to Brahminism, Sanskrit, the language of the Brahmin caste and culture, became the national pan-Indian idiom used for literary works not only by linguistically Aryan peoples but also by the dravidic populations. For this reason scientific literature also came to use Sanskrit.

The principal and oldest texts of Indian medicine are the *Samhita* or the collections attributed to *Bhela*, *Caraka*, *Susruta* (who perhaps lived in the first centuries of our era) and *Vagbhata* the elder, who was active roundabout the seventh century AD.

Of these collections only the first has come down to us directly, in a single and incomplete manuscript, whilst the others have come down to us in subsequent versions due to revisions carried out by different authors or compilers.

Their tracts constitute the subject of large commentaries by scholars, and have inspired specialist works on diseases and treatment and have been the basis for subsequent compilations on medicine.

In reality none of these collections constitutes a first attempt at a systematic description of medical science. On the contrary, all are based upon an already established tradition, in relation to the foundations of which the authors and compilers seem extraneous. They confine themselves to collecting and handing on the facts in their possession which they have received from tradition.

The *Ayurveda* is made up of eight parts – this division was so famous that the expression 'eight parts' or *astanga* is normally used to denote the Indian science of medicine.

They are: surgery, internal medicine, demonology, paediatrics, toxicology, methods to prevent ageing, and andrology.

The sources on the origins of the *Ayurveda* are very complex but one thing is certain: the tales on its origins are inseparable from those concerning the origins of the other sciences, that is to say the belief that the first teachings go back to the gods.

On the one hand we find the mythological tales concerning the *Ayurveda* , whilst the exposition of Ayurvedic principles based upon the observation of normal and pathological facts confers a strong connection with reality on this tradition. I would like to add that the *Vaidya* or medical doctors are divided into two categories according to who studied the texts directly and who practiced medicine on the basis of knowledge which had been handed down orally.

The Ayurvedic tradition is still rather alive in today's India, not least as a popular doctrine which, although at times it is said to be unchanging, in reality has undergone a certain development and has been enriched with new acquisitions.

Down the ages, for example, the Indian pharmacopoeia has assimilated foreign forms of medicine.

In the presence of and because of so much scientific literature belonging to Indian medicine produced in different epochs, the subsequent exposition of Ayurvedic principles referred to those drawn up during the classical period. This period, which constituted the high point of Indian civilisation, was the Gupta, and a post-Gupta period which covered the years 320 to 740 AD.

The Principles of *Ayurveda*

I referred at the beginning of this paper to the idea of *prakrti* and *purusa* because these two terms, in addition to having a philosophical meaning, refer to what we call man in terms of his physical make-up (*prakrti)*, which he receives at the moment of his conception and is his essence as a person (*purusa)*. And it is indeed man who is the subject of medical care and treatment.

In the Indian approach genetics are only responsible for the corporeal individuality, and this in turn supplies a body (with its psychological instruments including the sense organs) to the transmigrating psychic being.

The psychological continuum is bestowed with a new body at the moment of the new birth. The psychic individuality of the living being is independent of its perishable material vessel which comes from the person's parents.

The being is seen as being composed of five material elements (*mahabhuta*) and a psychic element (*cetana*) or consciousness which is raised by the *atman*. During transmigration the *atman* remains associated with the psychic being in order to descend with it in the embryo when it takes a new body at the moment of conception.

The nature of psychic individuality has provoked major controversies among the followers of the Brahmins who believe that there is a transmigrating substantial principle, that is to say an ontological substratum to psychism. The Buddhists for their part reject the idea of substance (with some exceptions, however – for example the Pudgalavadins).

The state of health or of illness is determined by the interconnections between the elements which make up the body. Diet, behaviour, the influence of the weather and of the climate, are also influential.

Experience has a very important role in establishing treatment but the medical practice of the *Ayurveda* is not empirical – the facts of experience are organised according to a general theory of physiopathology.

In some texts (or *Samhita*) the constituent elements of the universe are like the elements of the human body. Indeed, the mass of existing substances, however small they may be, both organic and mineral, are the result of a combination in varying proportions of the five fundamental elements which make up the whole of the universe – earth, fire, wind and space.

The body is fundamentally a complex and diversified aggregate of these five elements.

To these should be added thought (*cetana)* which resides in the heart. These principal elements make up the substance of the organism called *dhatu.*

They are seven in number and more specifically: organic liquid (*rasa*), blood (*rakta*), flesh (*mamsa*), fat (*medas*), bone (*asthi*), cartilage (*majja*), and sperm (*sukra*).

From the *rasa* come all the others because this is seen as being the primordial substance. Furthermore, in everything that exists there is a *rasa* (taste) which bestows properties and virtues on every individual thing.

This liquid has the characteristic of possessing a life force which is in the heart. Breathing (*prana)* is based upon this force which is distributed through the body through 24 channels called *dhamani* which carry blood and organic liquid.

We should also remember that in addition to ensuring breathing the *prana* also takes sensations and thoughts to the heart.

The interconnection between the three principal elements – that is to say wind, fire, and water – gives life and movement to the body. When these elements are excited or stop, illness and death intervene.

It is for this reason that they are called at one and the same time *tridhath* (or the three elements) and *tridosa* (or the three defects/illnesses) of the organism.

The wind makes up breath (*prana)*, fire is present in the organism in the form of bile (*pitta*), and water is in the phlegm or mucous secretions (*kapha* or *slesman*).

Each of these elements also takes on in turn a variety of forms and has a number of names.

The health of each person depends upon the balance between these three elements. The meaning of the term *dosa*, which at the outset meant an affliction and above all a pathological affliction of the breathing apparatus, of bile, or of *phlegma*, became under the influence of the philosopher *Samkhya* a defect/illness because in general use the term established an opposition with *guna* which meant a quality or virtue, the opposite of a defect.

In the commentaries on the texts of classical medicine we can see philosophy unite with medicine.

To summarise we could say that according to the philosophical-religious vision of *Ayurveda* the world and man make up an organism whose parts are connected to each other by a constant exchange of information and reactions which today we could define as the subject of the study of bio-rhythms.

For this reason, in assessing the state of the illness the Ayurvedic medical doctor also assesses other factors such as the sex of the patient, his age, his diet, his mental and emotional life, and the season then underway because there is a close link between the environment and physiology.

If we dwell in detail upon the forms of treatment proposed by the *Ayurveda* we realise that they are based in the first place upon the provision of medicines based upon herbs and minerals. What should be observed is that the use of these medicines is not seen as having a contrary pharmacological action but as having a natural synergism which can re-establish the balance between the three elements.

The basic elements of the *Ayurveda* to keep people in good health are not based upon special requirements but essentially involve common sense – personal hygiene, a correct diet, daily exercise (which is considered indispensable for everyone), and sufficient hours of sleep.

Good health is a concept expressed by the word *svastha* which literally means one who is inside his own normality, understood in a physical and mental sense.

To conclude this paper we should remember that the cultural exchanges between ancient Greece and India, which took place thanks to the mediating role of the Persian empire and the Greek colonies of Asia minor, allowed the interchange of a reciprocal knowledge of medical science.

Certain similarities between the Ayurvedic principles and the medicine of ancient Greece can be recognised in a special way in the Hippocratic texts *Per Cumèn* e *Per Fusèn*.

In the first we encounter the four humours or fluids (*cumo* or juices), blood, phlegm, yellow bile and black bile, while in the second a rather similar principle to that of the wind of the *Ayurveda* is expounded, that is to say that the organism lives and moves thanks to internal organic breathing which is identical to the wind in the atmosphere.

But the similarity between these two systems, which today we call holistic or psychosomatic, becomes more evident in the relationship between medicine and philosophy.

Despite the due differences to be found between the two systems, this can be seen in the affirmation formulated in the world of the Iatrosophists of late Hellenism, according to whom philosophy was the medicine of souls and medicine was the philosophy of bodies.

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RONARONG NOPAKUN

IV.4 Light in the Inter-Religious Dialogue: Buddhism

Introduction to Buddhism

Buddhism may be defined and explained from various standpoints: Buddhism, the teaching of the Buddha, the Enlightened One, proposes to develop mankind through purity, by means of morality, calmness, by means of concentration and clarity, by means of wisdom. Buddhism is a religion founded by the Buddha for the welfare of many, for happiness and for helping the world. People from all walks of life can apply the teaching in practice according to their ability and free will. Buddhism is a religion of reason and practice for self-help and self-reliance and for extending a helping hand to others out of kindness and compassion. Buddhism is both philosophy and practice. Though it accepts the existence of divine beings, it does not put belief in a supreme being as a significant part of the religion. Instead it teaches the followers to have qualifications such as moral shame and moral fear, making one divine in the Dhamma in this life; to be endowed with proper faith, morality, learning, generosity and wisdom. Furthermore, Buddhism teaches that one who is free from the defilements of greed, hatred and delusion is seen as a superior being.

Historical and geographical background of Buddhism

Buddhism came into existence in India some 2,600 years ago when the Indian Prince Siddharta became enlightened and hence came to be known as the Buddha , meaning the Enlightened One. There are two major Schools in Buddhism: *Theravada,* the teaching as preserved by the elders and *Mahanyana,* the later development. The former is practised in Sri Lanka, Thailand, Burma (Myanmar), Laos, Cambodia and parts of India and Nepal. The latter is more prevalent in China, Japan, Korea, Vietnam, Taiwan, Tibet and Mongolia. In the First Sermon, the Discourse of the Turning of the Wheel of Dhamma or Truth, the Buddha pointed out the Middle Way which gives vision, which gives knowledge, which is conducive to calmness, insight, enlightenment and *Nirwana,* the state of being free from all defilement and suffering. In brief, the Buddha taught people how to be happy and prosperous in a worldly as well as spiritual sense. Those who follow His teaching can select their way of life practicable for themselves.

The Buddhist symbol is in the form of a wheel with eight spokes representing the Noble Eightfold Path, which means the way leading to the cessation of suffering. This Path consists of: *Right View, Right Motives, Right Speech, Right Action, Right Effort, Right Mindfulness and Right Concentration.*

The Buddha is the Enlightened One who discovered the Supreme Truth. He did not force anyone to believe in His teaching with blind faith. The reasonableness of the Buddha's teaching, lies in the fact that it welcomes any critical examination at all stages of the path to enlightenment. He said "Do not accept anything on mere hearsay, nor by mere tradition, nor on account of rumours, nor just because it accords with your scriptures, nor by mere suppositions, nor by mere inference, nor by merely considering the appearances, nor merely because it agrees with your preconceived notions, nor merely because it seems acceptable, nor thinking that the recluse is our teacher." And then the Buddha further instructed people to consider everything carefully. He said "When you know that these things are bad; these things are blameable; these things are censured by the wise; undertaken and observed, these things lead to harm and ill; abandon them. And in contradiction, when you know that these things are good; these things, undertaken and observed , lead to benefit and happiness, enter on and abide in them."

We can live happily without believing in any religion if happiness means physical well-being. But a human being consists of two major aspects: body and mind. To have a fully developed and happy life, one needs to nourish both body and mind. In this case religion can provide the guidance and the path to develop the mind and spirit along with the body. According to Buddhism, everyone is free to consider and investigate Buddhist teaching before acceptance. Even after acceptance one is free to select any particular part of the teaching to put into practice. The Buddha has given various practical formats suitable to people of different tastes and tendencies.

The Five Precepts are not laws but they are self-training rules that lead to moral practices and right behaviour. Since one does not live alone, living in society requires self-awareness, self-control, adaptability, a non-violent attitude and good will. The Five Precepts are to abstain from killing, stealing, sexual misconduct, false speech, and intoxicants which cause carelessness. One should be kind, honest and mind-

ful. Then our society will reach the goal that persons can live together peacefully and in mutual trust. These are the five commandments: You must not kill, You must not steal, You must not tell a lie, You must not commit adultery and You must not take strong drinks.

Buddhism teaches that loving-kindness should be diffused to all sentient beings, be they human or non-human. If the world follows the teaching of diffusion of universal loving-kindness, conflicts may be solved not by confrontation but through peaceful means. Buddhism denies the attachment to the permanent soul, but admits the continuity of life from one to another, as long as one does not reach *Nirwana* or the utter extinction of the fire of defilement and the fire of suffering. Whenever human or animal beings continue to transmigrate in the cycle of life from birth to death and from death to rebirth, kamma still continues to give its results to the doer. The Buddha points out practical ways and means to achieve the three levels of advantages and benefits.

First: *The Present Benefit,* which means economic and social profit by the effort of earning a livelihood, protection of what one has acquired, having good companions and a moderate way of living. Second: *The Future Benefit,* which means the profit based on morality and virtues by faith, morality, generosity and wisdom. Third: *The Absolute Benefit,* which means the highest profit through freedom from defilement and suffering by morality, concentration and wisdom. The practice of this triple study will lead one to deliverance.

History of Buddhism in Thailand

As we know Buddhism reached its height of prosperity in India during the reign of Emperor Asoka (273 BC-233 BC) He founded a big empire in India through conquests and at the cost of numerous lives. The sight of so much bloodshed disgusted him. He gave up fighting and lived ever after in search of peace. The Buddhist religion pleased him, and he became a great patron of Buddhism. During his lifetime he sent out Buddhist missionaries to various countries to preach Buddhism including Thailand. Buddhism was then flourishing in Ceylon and a learned Buddhist priest came to Nakorn Sitammarat in Thailand from where King Rama Kamhaeng of Sukhotai (1275-1317) invited a learned Ceylonese monk, so that he could help him to teach his people the new religion.

The Reign and Reforms of King Chulalongkorn (1868-1910)

King Mongkut (Rama IV) was the first Chakri King to embark seriously on reforms based on Western models. He concentrated on the technical and organisational aspects. He was a scholarly, conscientious and humane monarch who ruled at a difficult time in Thai history. The reforms and foreign policy of King Mongkut were carried on by his son and successor, King Chulalongkorn (Rama V) who came to the throne a frail youth of 16 and died one of Siam's most loved and revered kings, after a remarkable reign of 42 years. Indeed modern Thailand may be said to be a product of the comprehensive and progressive reforms of his reign, for these touched almost every aspect of Thai life. During this reign, King Chulalongkorn's contribution to education was also to prove of great significance to modern Thailand. "Public instruction" or education, health and medicine became more secular than ever before in Thai history. The King was eager to send Thais abroad for their education partly because the country needed skills and knowledge from the West and partly because the Thai students abroad could come into direct contact with Europe's elite. King Chulalongkorn kept Siam an independent sovereign state in spite of all crises, and all the while he strove to uphold Thai cultural, artistic, and religious values. When King Chulalongkorn died in 1910 a new Siam had come into being. The Thai kingdom was now a more centralised, bureaucratic state partly modelled on Western examples. It was also a society without slaves, with a ruling class that was partly Westernised in outlook and much more aware of what was going on in Europe and America. Technologically, too, there had been many advances: there were now railroads and trams, postage stamps and telegraphs, public health and medicine.

Buddhism in the Kingdom of Thailand today

Thailand is the country located in the central part of Southeast

Asia. Its landscape covers 514,000 square kilometres with a population of 60 million people. The nation is governed by a constitutional monarchy, with the king as head of state with a representative legislature. Buddhism plays a large part in all spheres of public life from birth to death, in all states of life, on happy as well as on sad occasions. Although Buddhism became the primary and state religion, Thais have always subscribed to the ideal of religious freedom. Thai constitutions have stipulated that Thai kings must be Buddhists, but monarchs are invariably entitled "Upholder of all Religions". Consequently, the government, through the Religious Affairs Department, annually allocates funds to finance religious education and to construct and restore monasteries, mosques and churches.

According to the Constitution of Thailand BE 2540 (1997) the right of the people to freedom of religion is protected and organised as follows: *Section 38.* A person shall enjoy full liberty to profess religion, a religious sect or creed, and observe religious precepts or exercise a form of worship in accordance with his or her belief: provided that it is not contrary to his or her civic duties, public order or good morals. In exercising the liberty referred to in paragraph one, a person is protected from any act of the State, which is derogatory to his or her rights or detrimental to his or her due benefits on the grounds of professing a religion, a religious sect, or creed or observing religious precepts or exercising a form of worship in accordance with his or her belief from that of others.

Other Religions in Thailand

Considered an essential pillar of society, religion is not only the major moral force of the Thai family and community but has also contributed to the moulding of this freedom-loving individualistic and tolerant people for many centuries. That there is complete freedom of worship in Thailand, without any ethnic or racial discrimination, should therefore come as no surprise to any serious student of Thai society

Muslims comprise Thailand's largest religious minority and are concentrated mainly in the southernmost provinces of Thailand. Islam is said to have been introduced to the Malay peninsula by Arab traders and adventurers during the 13th century. Most Thai Muslims are of Malay descent, reflecting the common cultural heritage. Ninety-nine per cent Sunni and one per cent Shi'ite, Thai Muslims enjoy inspirational and financial support from His Majesty the King, who provided money for translating the Koran into Thai. Moreover, His Majesty appoints a respected Muslim religious leader as Chularajamontri, or State Counsellor for all Islamic affairs. The government also provides funds for building and renovating mosques. In some southern provinces family and inheritance cases are judged according to Koranic law with a Muslim judge, or kadi, presiding. There are approximately 2,000 mosques in Thailand, about 100 of which are in Bangkok. Some 200 Muslim schools offer secular as well as religious instruction.

Christians Christianity was introduced to Thailand by European missionaries in the 16th and 17th centuries. These early Catholic missionaries were later joined by Protestants of the Presbyterian, Baptist, and Seventh-Day Adventist sects. Their converts mainly came from ethnic minorities such as the immigrant Chinese. Despite the small number of Thai converts, Christians have made several major contributions in the fields of health and education. Thailand's first printing press was introduced by Christians, and King Mongkut (Rama IV) learned English and Latin from Christian missionaries. Christians introduced Western surgery, made the first smallpox vaccinations, trained the first doctors in Western medicine, and wrote the first Thai-English dictionaries. Thailand's Christian population is estimated at 0.5% of the total population.

Hindus and Sikhs The approximately 20,000 Indians residing in Thailand are almost equally divided between Hindus and Sikhs. The Hindu community is mostly concentrated in Bangkok, where it worships at four main Hindu temples. There are also several Brahman shrines at which Hindus and Buddhists alike worship. The Hindus operate their own school where the curriculum is based on the Thai education system, though in addition to Thai it teaches Hindi, Sanskrit and English. The Sikhs, too, are concentrated mainly in Bangkok. They operate a free school for poor children, regardless of caste, creed, or religion, and through several charitable associations they support the aged and the sick.

Healthcare

Healthcare at the Buddhist Temples in Thailand

Since the old days, Thai people have aspired to establish Buddhism as the core of Thai culture and a pillar of society. It is customary to build a pagoda containing relics of the Lord Buddha at the heart of each principal city. As the societies evolved and became more secure and communities expanded, the Thai also built temples within their communities, which were the centres for Thai life and used to be the school of Thai children for the basic education. The Buddhist Temples have been the centre of the medical and health care of the Thai people for a long time and the monks used plants and herbs as medicine to cure people.

High quality of research of medicinal plants in Thailand

According to Her Royal Highness Professor Dr. Princess Chulabhorn of Thailand, president of the Chulabhorn Research Institute, we can explain the usefulness of plants and herbs for the medicine in Thailand as follows: throughout the ages, humans have exploited the cornucopia of nature as a source for medicines for the treatment of a variety of diseases. In Asia several thousand plants species are utilised for medicinal purposes. We estimate

that for some 3.4 billion people in the developing world, or 88% of the world's population, plants represent the primary source of medicine. Our country, Thailand, as a tropical country, has long enjoyed the luxury of an innumerable variety of tropical plants. In this regard, the Thais have a long

tradition of folklore medicine, utilising medicinal herbs and plants. Natural remedies that, although undocumented, may have been used for many thousands of years by the human race must be appropriately catalogued to ensure that vital ethnomedical information is not lost forever. Due to its paramount importance, it is thus a matter of utmost concern to public health and indeed to human life that urgent action is taken to prevent further diminution of actual and potential availability of medicinal and biological agents. Drug discovery from natural products can address the interdependent issues of biodiversity conservation, economic growth, and human health. Many clinically useful anti-cancer drugs have been discovered from various plants. The potential of natural products as therapeutic agents in the treatment of malaria is enormous. Quinine, from the barks of the cinchona tree which grows in large plantations in Asia, was introduced as an antimalarial more than a century ago. The Asians have a long history of use of a herb called Qing hao (Artemisia Annua) for the treatment of malaria. *Stephania erecta* has been used in Thai folk medicine as a skeletal muscle relaxant and an analgesic. Peroxide compounds have also been isolated from some plants of Thailand which have been used in Thai folk remedies for malaria. *Phyllantus amarus* has been traditionally used for the treatment of jaundice and other hepatic diseases. The active principle of *Gloriosa superba* is the alkaloid "Colchicine", which is isolated from the dried tuber of the plant and has been used for the treatment of arthritis.

Thailand's world famous traditional treatment

Thailand is not only famous for its high standard of modern medical treatment, which is part of Ayurvedic medicine. Thai massage has a long history of therapeutic healing and is the product of ancient oriental medicine. Its origins date back to India 2,500 years ago. The founder of the massaging art was "Master Chiovak Kormar Phaj", a doctor in Northern India, who was a disciple of Buddha. These massage techniques were handed down to Thailand along with the expansion of Buddhism throughout Asia by Buddhist practitioners. Thai massage was mentioned in medical scriptures written on palm leaves onwards from the 17th century onwards. These old massage texts seem as important as Buddhist scriptures, but most were destroyed and disappeared during the destruction of Ayudhaya, the old Thai capital, in 1767. The remaining scriptures were reutilised in 1832 by King Rama III. He ordered all available knowledge to be inscribed on stone slabs which were set in the compound of the Temple of the Reclining Buddha or Wat Po in Bangkok. These stone inscriptions can still be seen there today.

Thai massage is considered to be an excellent method of self-care. In practical Thai massage we usually use the instinctive acts of touching, rubbing, kneading and stretching different parts of the body when there is pain or discomfort. Thai massage is certainly an invaluable method of supporting good health and well-being. If it is done in combination with taking nutritious food and leading a healthy way of life, it surely provides fitness and comfort your body.

High standard of health care today

Thai private hospitals are widely accepted. Many multi-national industries have signed contracts for their employees to receive medical check-up and treatment in Thailand. Being confidential and worthy, Thai medical doctors are able to treat foreign expats and employees residing in the ASEAN countries. Thai hospitals today have a standard equivalent to Western Europe and USA. The standard of physicians, specialists and of nursing is excellent and covers every medical field. Under the Ministry of Public Health's strict regulations and control, the mission of the hospitals is to be the leader in high standard service.

Conclusion

In conclusion we can say that the Thailand of ancient times was under the influence of Buddhism and that the Buddhist temple played an important role in the life of the Thai people. It is the pillar of society and it is the centre of social welfare, education, healthcare and medicine. When the Muslims, the Catholic Missionaries and the Protestants arrived in Thailand they also became centres in the fields of health and education and of the social life of the people who obeyed and respected them in their own communities. That was until Thailand had a great social reformation in the reign of King Rama V more than 120 years ago. Since then Thailand has developed modern technology and with it the system of health care and medicine, which today is similar to Western European Countries and the United States of America.

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Section III
Action to be Taken

MARIO BIZZOTTO

I: Pastoral Care in Medicine Today

The title of this paper in Italian ('azioni da realizzare: la cura pastorale nella medicina oggi') lends itself to a lack of clarity and to hopes which may not be realised. For this reason it would be a good idea to begin by clarifying matters. This title might make one think of the set of forms of technical organisation which should be set in motion in the sphere of pastoral care: for example the administration of the sacraments, the encouragement of the staff who provide services, and the promotion and fostering of groups for the humanisation of hospitals.

But it could also refer to the redefinition of religious activity which has been proposed following the ongoing revision of the concept of health and illness advanced by psychosomatics, both in relation to the updating of the figure of the spiritual assistant in the hospital environment and with regard to his possible integration into the organism responsible for care and in response to the requirements needed for effective contact with the sick. It is upon these subjects, issues and questions that this paper wishes to dwell. Indeed, to such subjects the title translated into French and English more explicitly refers – 'la prise en charge pastorale dans la médecine d'aujourd'hui' and 'pastoral care in medicine today'. The emphasis is on the meaning of pastoral care in medicine today.

1. Rethinking the Concept of Health and Illness

A few decades ago if one said that it was not an organ but the whole man with his own physical and mental components which fell ill this could have been something rather new. Now, far more than being a novelty that has become a stereotype. This statement, which began in part with philosophical anthropology, has brought into play other disciplines: sociology, psychology and not least pastoral theology. Health and illness have thus acquired a much broader meaning than that to be found in traditional medicine.

This fact could not escape the 'Nota' of the Italian Bishops' Conference (1989) which bore the title 'la pastorale della salute nella Chiesa italiana' ('pastoral care in health in the Italian Church'). In sections 6-7 of this document we read: 'the concept of health... is not to be related only to physical or organic factors but also involves the psychic and spiritual dimensions of the person... The concept of illness has also changed. It is no longer definable as a mere pathology, to be perceived through laboratory analyses. Illness is also understood as existential ill-being'.[1]

This psychosomatic conception marks a major change in medical science and thus in pastoral care as well. A field of analysis has been opened up which at one time was unthinkable. Recently, attempts have been made to clarify, on the basis of sociological observations, whether the factor of religion effects health and the development and evolution of an illness. The answer as expressed in statistical facts and data allows of no doubt on the matter.

In the United States of America studies have appeared based upon inquiries carried out into believers and non-believers, rigorously practicing believers, and believers who are rather lukewarm to such practice. The results have produced facts which are clearly in favour of those who translate their religious beliefs into an actual way of life. The examples produced are very large in number. Prof. Matthews has recently published a large volume entitled 'il fattore fede. Il potere della pregiera per guarire' ('the faith factor. The power of prayer to heal').[2] This text is rightly highly regarded both because of the newness of its argument and because of the scientific rigour which it employs.

Some facts can be presented here by way of example. Taking a large sample of 91,909 individuals, the number of deaths of religious people who practiced their faith as opposed to non-believers was 50% in the case of cardiovascular diseases, 56% in the case of emphysema, 74% in the case of hepatic cirrhosis, and 53% in the case of suicide.[3] Another example: death rates in patients affected by serious heart disease who then underwent an operation was 9% but in the case of believers the figure fell to 5%. The same differential relationship can be found in other other areas such as prevention, the family, divorce, and drug-taking.[4]

The statistical picture, although expressed in mathematical terms, lends itself to many interpretations. One could advance the hypothesis that the advantages of the believer are not so much due to

his faith as to the consequences which derive from that faith, or rather to a serious lifestyle, to good diet, and to moderation in habits. In other terms, that one could think that if another value took the place of faith, for example, sport, fitness, physical efficiency or care for one's health, then one would obtain the same results. One would then arrive at the conclusion that the well-being of an individual should not be attributed to religious belief in itself but to the observation of the hygienic norms which come from that belief. It has been observed, however, that although such norms are scrupulously observed by everyone the results and the above-mentioned differences do not change. It should be added that in the process of the recovery of people who are practicing believers, the medicines and drugs have different effects and there is a great possibility that especially difficult operations will be overcome by the patient.

Matthews in particular lays stress upon the effectiveness of praying in therapeutic treatment, and to such an extent as to propose that the medical doctor should not limit the exercise of his activity to prescribing medicines and a relevant diet but should also engage in prayer with those patients who want to do so. This rather unusual proposal could be accused of having a lack of realism, but it could not be accused of having a low level of logical consistency. Indeed, it follows on from what is demonstrated by the statistics. Once the health-inducing role of prayer has been observed and demonstrated it is logical for the person involved in care and treatment to use all the means he has available to accelerate the patient's recovery. It is known, however, and the author himself points this out, that the proportion of believers amongst medical doctors is much lower than amongst ordinary people. It is not possible, therefore, to ask a medical doctor to engage in a religious practice in which he does not believe.

If this task cannot be performed by a medical doctor, it can however be performed by a religious assistant. Such a person is not present in the world of health merely in the form of a visitor – he is there as a part of the helping and caring personnel. If illness involves the whole man and this is to be defined as a religious component, it follows from this that the contribution made by the chaplain or on his behalf is highly beneficial.

2. The Redefinition and Practice of Pastoral Care

The reference to the connection between medicine and religion acts to place the figure of the religious assistant in a new light.

Meyer-Scheu, the author of a large number of publications on the subject, complains that the religious worker within hospitals is now undergoing a crisis of identity. The concept of traditional medicine previously confined such a figure to the margins and made him superfluous. The effective function being able to contribute to the process of healing was not attributed to him.[5] The new concept of illness has involved certain amendments to a concept which at one time held total sway. Pastoral care is now acquiring a precise importance which is almost universally recognised. There are thus favourable premises for an overcoming of the 'external and internal crisis' observed by Meyer-Scheu.

In discussing this crisis, its causes are also brought to mind, for example the poor scientific grounding of spiritual assistants, the lack of sensitivity of certain diocesan hierarchies, and the fact that pastoral care amongst the sick is often entrusted to people who are no longer young and effective in their work. Because of this crisis we have before us an especially favourable opportunity to attribute to pastoral care its due importance. Its practice postulates inescapable requirements of a religious, intellectual and psychological character.

The person who commits himself to assistance to the patient must feel committed to the task. In an ascetic context one talks about vocation or charism. This is a fundamental point of departure. Upon it is built technological knowledge and above all else through it one discovers the means by which the message can be communicated. The level of creativity and adaptability, which are able to meet the various situations, determines the effectiveness of the pastoral action. Every sick person has his or her own story to tell which is not equal to other such stories. The ability to understand cannot be learnt from lessons at school for the simple reason that this is not something which can be taught.

The application of acquired knowledge is only achieved through personal experience; it is something which is learnt independently. There are no teachers who can teach it because there are no pre-prepared answers. Every individual has his or her own questions and each person reacts to them with his or her own answers.

The danger is that in some way the ancient docetist heresy is reproduced, which in our case leads to a failed embodiment of the message, to a sterile presentation of principles, or to a desire to save doctrinal consistency rather than the individual involved. People become worried about the wishes of God, like the friends of Job, and forget about the concerns of the person who is being spoken to.[6] Doctrinal concern is more than legitimate, however it should be counterposed by the duty to engage in solidarity. The right time and place should be found for such solidarity. Christ can be

reached by touching the hem of his cloak, and then from the cloak itself (Mt 14:26) one goes on to meet his face. First must come the person with his or her human riches which must come out into the light; the role emerges only concomitantly.

Benevolence and readiness to help belong to the same postulates of evangelisation. One cannot evangelise with doctrinal formulas, and even less by using general phrases which cannot match up to the unrepeatable nature of the contingent situation. The same biblical quotation is not always equally effective, and a facile use of such a reference gives the impression that the speaker does not want to express himself with his own words but wants to use the Bible as an instrument which acts as a shield in relation to his own feelings. The relationship then merely skates the surface and fails to establish a contact which goes from soul to soul. Going directly to the language of faith and morality provokes reactions of rejection on the part of the patient and gives the impression of mere declamation without there being any sharing in the suffering of the other person.

The patient asks for neither learning nor erudition from the person who draws. He or she asks, rather, for nearness and participation. When learning is used to conceal one's own emotions, one remains outside the situation of the suffering person. One is in front of the patient and the nearness is of a mere physical kind, what Adorno defines as the nearness of two geometric points.[7]

The first pre-condition in order to reach the patient and to redefine pastoral care is vocation. This is what leads to the approach which should be engaged in, the creation of answers which are more suited to the specific situation, to sharing in the condition of the other person and to choosing channels through which the message can be communicated.

3. Training and Co-operation

The requalification of religious assistance is achieved through vocation but also through ascetic, theological and humanistic training. The 'Nota' of the Italian Bishops' Conference calls for people to be 'in harmony with the development of learning and medicine and the development of theological reflection on ecclesial practice', and the apostolic letter 'Salvifici Doloris' devotes its last sections to the subject of professional training.

The assimilation of the evangelical spirit which sends out its messengers by disarming them forms a part of ascetic training. The disciples dedicated themselves to their mission without having the right to engage in revenge. They were without defences, they presented themselves in the form of poverty and humility. Similarly, the religious representative in a hospital is an envoy who does not go down the corridors like the medical doctors or other personnel. His presence is different, and can be refused. This possibility places him in a humble condition. He is sent out with the task of proposing and offering a service, whose function is left to the free choice of those people he is talking to.

Faber speaks about the chaplain as having a role similar to that of the clown in a circus. The comparison at first sight might appear rather disorientating. However, if one reflects for a while one realises that the comparison is an effective one and can bring out certain meaningful details. More than any other figure, however serious and committed that figure may be, the clown enables us to understand the lowness and the powerlessness of man. Whereas everything and everybody are involved in striving for success, he shows the other side of the coin, puts the events of life in their right place, he interprets them through their failings and their dire aspects, and takes part in them. The presence of the priest in a hospital is something of a similar nature. He is an individual who places himself next to suffering people where he, too, is weak and involved in the disorientating unfolding of a malady. In sharing their suffering his approach is to bring the words of solidarity and hope. Those who are around him – specialists, surgeons and scientists – can draw attention to successes which underline the indispensable nature of their work. The chaplain can associate himself with their successes. His work, which is not easily noticed, must express the humble spirit of the Gospel.[8]

Ascetic training is flanked by professional expertise, something which is called for by a list of authorities who have campaigned for psychosomatic medicine. Frankl, Weizsäcker, Plhgge, and Balint are some of the many figures who have lain stress on the importance of the personal relationship with the patient. Gebsattel in particular has laid stress in the training of the spiritual assistant on the need for his co-operation with the psychotherapist. In his activity this authority has encountered pathological cases whose solution in his opinion he believed required the knowledge of a theologian. And such help is mutual. The therapist can discern whether his patient is sustained by authentic faith or disturbed by a false religious experience. In the first case faith becomes a stimulus for the promotion and liberation of the person; in the second case it has an oppressive meaning and is seen as complex of exterior practices, cults, rites, rules, prohibitions, and a collection of artificial elements. The patient who is called upon to establish clarity in relation to himself or himself, also establishes clarity with his or her faith. The theologian intervenes to demonstrate what to believe means, and to direct the patient towards the centres of gravitation of the religious experience with his salvific message.[9]

The person who provides care, whether he or she is a psychotherapist or a theologian, co-operates in re-establishing a new equilibrium within the patient, and this is always done on the assumption that the patient possess an inner harmony and is at peace with himself or herself. The person who is disturbed by conflicts and lives in an anxious state is not able to communicate what he himself, or she herself, does not actually possess. His or her action will not have a healing effect. The person,

for example, who has had negative religious experiences is not able to reassure people who have the same disturbances.[10] A scrupulous spiritual director, a formalist, or a fanatic, needs to take care of himself or herself before he approaches other people. In the training of the spiritual assistant common sense and psychological stability are basic requirements.

Gebsattel lays great emphasis on the need for the professional and humanistic training of the spiritual assistant. It is not enough to make oneself available in a selfless way. It is important to have a knowledge of psychic mechanisms, otherwise the form of help that is offered is only apparent, and will by-pass the problem rather than getting to its roots.[11] The authenticity of the action that is taken should be subject to verification. Behind the feeling of solidarity other motivations can conceal themselves – vanity, pride, an impulse to self-assertion, and flight from personal problems. Behind the mask of altruism equivocal motivations can often be found to be concealed.

There are guiding techniques and strategies which are the necessary premises for engaging in a fruitful dialogue. The chaplain knows how to act in a suitable way when he accepts the conflict between the religious message and reality and he elaborates it by placing it in experience and personalising it. He thereby becomes its authoritative and credible witness. He does not need to turn to outside sources. His word is born from an internal source and is communicated through a personal travail of difficulties and suffered questions. The person who has struggled to overcome the difficulties which are encountered in the presentation of faith is better able to understand the difficulties of others.[12]

One of the most frequent temptations, and most damaging in pastoral terms, is recourse to polemics or to forceful defence in relation to one's own points of view. All this conceals a badly suppressed inner turmoil and this is something which ends up by blocking every possibility of dialogue. Gebsattel relates the observation of a patient in relation to this point: 'if the chaplain comes near to me with his morality he will not give me any help... he will chain me up, for this reason I refuse to seek him out'. One sick woman dreamt that the priest was placing a suffocating vase on her head. This image needs no comments and explicitly communicates the unpleasant impression of the person who feels intimidated and that he or she is approached with impositions.[13]

The difficulties of a doctrinal character cannot be resolved without reference to the situation of the person who is being talked to. Indeed, a proposal which is wise takes account of the understanding and the level of receptivity of the other person. The point of departure for communication does not confine itself to safeguarding orthodoxy or to moving from outside in a coercive way. Faced with an individual who rebels when faced with every religious idea I cannot speak to him or her about the love of God. Another task has to be performed first of all – to see the causes of his or her resentment and only after neutralising his psychologically disturbed condition is it possible to approach the religious side of things.

In order to be meaningful in carrying out his religious activity the chaplain or the person who acts on his behalf must have an ascetic, theological and humanistic training. His contribution will be more effective in terms of the healing of the inner person the more he is able to place himself in tune with the other forces working in the field of health and health care. For this reason, the approach of faith is something which is especially arduous and goes beyond merely theological information.

The role of the chaplain, however, remains a difficult one even after he has met the essential requirements of an ideal training. Contemporary man breathes in a secularised climate which is deaf to the transcendent perspective. He is led to resolve his problems by entrusting himself to exclusively terrestrial means and instruments. It seems that he directs his attention not to the question – how should I shape my relationship with God? – but to another question, namely how should I organise my life without God?[14] Awareness of contemporary hegemenous culture forms a part of the training of the religious assistant and is an indispensable requirement of that training.

The theologian and the therapist often find themselves involved in relationships involving necessary interchange. Their co-operation is required by situations in which the religious experience and psychic mechanisms are intertwined. The theologian administers grace – which according to the ancient adage presupposes nature – not, however, nature distorted in its balance but nature which has reached a level of maturity. It is upon this basis that one can build an authentic experience of faith. Co-operation between the theologian and the therapist becomes indispensable in cases of neurosis connected to religious factors. Both have their own field of specific action. The former is called upon to explain the contents of faith; the other is required to discover the causes of a mental disturbance. The observation made by Jung is more than relevant: 'if you ask me why you must be the custodian of your brother, I cannot provide you with an answer. I can, however, tell you me why you have asked me this question.'

In the analysis of the psyche one can see how certain dysfunctions with presumed religious origins are in reality caused by factors which have nothing to do with religion. Religion is called into play as a cover-up which conceals the real reasons for the disturbance. One knows for example how a child who is morbidly attached to his mother feels constricted in his relationships with other women. It can happen that he attributes his disturbance to a moral motive – to the fear of sin.

Freud located the cause of many neuroses in religion. He did not understand that a good religious education contributes to making the individual responsible and free. At times the neurosis can be caused by the removal of the religious element. In this case as well the work of the therapist takes

place at the side of that of the theologian.[15]

It remains to us to find the way by which to reach the other person and open up a relationship of communication with him or her. Diedrich has dealt with the question which has been posed to him by many religious assistants – what should I do? He has no other answer than the following: you should go and see the sick person.[16]

4. Visiting the Sick Person

The presence of the religious assistant means that the visit to the sick person is the most relevant moment for the expression of his training. Here something decisive comes into play; here the humanistic meaning of his task of evangelisation comes to the fore. Knowledge is at work – one speaks, one sees, one stays, communion takes place accompanied by an intense gamut of emotions of the most varied kinds – suspicion, caution, trust, openness, sympathy, confidence, and joy. It is within this framework that the opportunity presents itself to tackle the religious question and the situation arises when it is possible to follow the advice of Prof. Matthews to pray with the sick person and administer the sacraments.

From a Christian point of view visiting the sick is one of the works of mercy (Mt 25:31-40; Jn 5:14). The more frequent the visits the more likely that there are opportunities to engage in dialogue, the setting in motion of which requires the prior overcoming of prejudices and the creation of a new basis of understanding. If pastoral care is called upon to take active part in the process of healing, this should be expressed in drawing near to the sick person and dedicating time to service to the patient. A fleeting and perhaps rare appearance cannot have any beneficial effect and becomes something reduced to a mere formality. In order to know each other it is necessary to spend time in each other's company and to listen to each other. In the exchange of conversation many questions emerge and the most frequent question concerns the meaning of illness. The chaplain acquires the role of a person who is called upon to provide answers and this is no easy task. Its performance goes beyond knowledge; the chaplain is involved as a person with his own sensitivity.

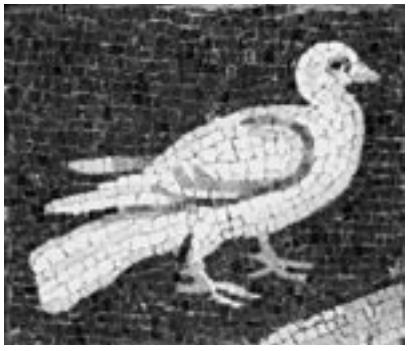
The question of the sick person is a pseudo-question and says more than its literal form actually expresses. It real meaning is to be found more in what is behind the words spoken than in the words

themselves. It does not have the meaning of an observation made by the student to the teacher. It does not come from the bench of a school but from a bed of pain. It transmits the desire for nearness. It is certainly the case that all this is not yet transcendence or openness to the religious side of things. On the other hand, the theologian does not begin by offering doctrinal concepts but by sharing the experience of the other person. He thereby follows the example of Christ.[17]

The encounter with the religious message has psychological aspects which stimulate effective resources in the sick person which in turn work towards a successful end to the illness. This malady, however, can be incurable and have no other epilogue than death. The expression of brotherhood remains equally valid but it must not become an occasion for the raising of false hopes or the telling of lies, things which are convenient to those who are defeated by science and above all to those who assist such people. The suffering person is really accompanied when he or she is helped to clarify his or her situation and to adapt himself or herself to that situation. This is a work which has its price but it is also something which leads to maturity. The question which has always been debated, namely whether the truth should be communicated to the sick person, generally applies to those who run the risk of dying.

However, this is not the only task that the spiritual assistant is called upon to perform. There is also the case of the person who suffers a major physical handicap – the amputation of a limb, paralysis, or the loss of sight. The sick person who previously lived a full and vital life is forced to radically change his or her lifestyle. The crises which await him or her will involve him in a struggle which he or she will not be able to overcome on his or her own. The spiritual assistant, with his experience accumulated in the world of pain, can be at the side of the patient and be a companion in that patient's struggle. The appeal to transcendence, a necessary leap in order to give meaning to the misfortune which has occurred, helps the patient to resign himself or herself to the situation and to recover peace of mind. This, however, should be done with consideration and without speeding matters up. Then the time comes for the moment of prayer and for hope.

Today, medicine raises hopes in the chaplain. These can be fulfilled above all in the encounter with the infirm person. The visit to the hospital is centred on the sick person and the patient is the primary individual with whom he talks, but this is not the only such person. Others are then added – the relatives of the patient, the nursing staff, technicians, and medical doctors. The chaplain also has a task to perform in relation to these people. In an epoch which is fascinated by technology, the idea of service runs the risk of being reduced to a mere act of work.



Hospitals increasingly tend to be secularised and end up in a levelling process which resembles the climate of the factory. In this environment the spiritual assistant keeps alive the appeal to the person.[18] In representing the Gospel he represents man with his human and religious needs. Indeed, his action is not based upon technology but is directed towards the religious and moral values of man – the conscience, brotherhood, love for one's neighbour, and the understanding which exists between one soul and another. The danger of turning the other person into an object is counterposed by the reality of the person who is encountered with his specific rhythms and emotions.[19]

The patient is certainly a subject who needs services which technology administers with the help of amazing discoveries. However, he or she also needs psychological supports and clarifications of the problems of his or her life. Perhaps for the first time, tied to a bed and forced to pass hours on his own, the patient finds that he or she is taken by surprise by a number of questions, he or she discovers needs that the exercise of his or her profession had concealed from him or her. In drawing near to the religious assistant the patient encounters that help and those clarifications that his or her situation of crisis requires.

In all the services provided by hospitals are to be found anxiety and hurry, the rationalised time of technology which puts us in a line, making us wait for our turn. Once this has come we are pressed by those who are behind us. Such cannot be the case in the conversation with the pastoral worker who is called upon to interpret human time, that time which is suited to need. It provides calm and tranquillity. For this reason, amongst the suggestions made to those who visit the sick is to be remembered that of sitting down so as not to give the impression of being in a hurry. One does not come to go away immediately; one comes to make oneself available.

All this is required not only by the rules of good behaviour but also by the duty to engage in Christian witness. The service of the religious figure in hospitals is performed by a person trained in relationships with other people and educated in the spirit of the Gospel. The religious figure presents himself with the badge of faith which is expressed in his way of behaving and speaking rather than in the performance of rites or in the saying of prayers. This much is clear – the chaplain is really himself when he brings and revitalises the sacred action; however, he has to do this without falling into the artificial. In this epoch of secularisation everything that is external apparatus or mere ceremony stands out, and rigid attention is paid to playing everything to the book. In this way the creative and personal action which is suited to the contingent situation is forgotten about.

The Christian message imposes itself when it is expressed through a spontaneous approach. It does not need to be sought for intentionally. It is born naturally like the breathing in and out of the lungs. This is true not only in relation to what is said but also as regards the way in which one's own beliefs are communicated. Secular culture does not reject authentic witness – it rejects it if one halts at mere outwardness or the communication of contents which are not expressed in one's own experience. There is no need to talk directly about Christ, nor to move immediately to suggestions that the sacraments should be administered. 'What is decisive is not so much that we speak about Christ but that we make him present as our partner'.[20] Everything that is mere outwardness does not find a place in the Gospel. If one were to try to present the Gospel while wearing masks, a betrayal would be committed towards it. External expression has meaning if it reveals the inner man – that is to say the world of the soul. To visit a sick person is to be aware of another person and at the same time to communicate oneself. A mask communicates nothing, indeed it conceals and leaves the individual closed up within a wounding selfishness. Once a real relationship has been created, prayer and the suggestion that the sacraments be administered have meaning. Outside the context of knowledge in the contemporary secular environment, religious action runs the risk of being reduced to an isolated episodic experience which is detached from the heart of existence and suffering.

The message which the witness to the Gospel bears in the world of pain is supported by hope and the prospect of life beyond. It becomes difficult in a culture dominated by the contingent and captured by the reality of the senses. The messenger himself is a part of the world of the person he is speaking to; he perceives the difficulties of his mission and does not hide them. With humility he presents himself as a person who believes and who has learnt amidst the sad events and episodes of life to hope and to pray.

The visit to the sick has always been seen as the salient point of pastoral care. Today it is recognised as being valid by medicine itself, and this despite the influences of secularisation. It is an instrument which is more necessary than useful, and which is required not only in extreme situations but by the very constitution of man who loves good for good's sake, is happy when he discovers it and in discovering it can realise it. Visiting the sick achieves its final objective when it moves over into faith, is expressed in prayer, or takes place through sacramental action. This is certainly the most gratifying moment for the chaplain. The appearance of religious need brings about the achievement of a psychologically optimal situation with regard to healing.

The reference to prayer brings this paper to its point of departure. Matthews includes prayer in his medical practice. He observes among other things that it is irrational to speak about the spiritual

character of medicine and not to take advantage of prayer.

5. Human Promotion and Prayer

When illness pushes a person to pray an experience of special anthropological value takes place. The man afflicted by pain and who is open to invocation sees himself for what he really is – a weak and precarious being.

There is much talk about the humanisation of medicine. Such humanisation never touches its highest form more than in situations of trial and difficulty when it frees thought and raises it to God. People have always prayed in the presence of disaster – in concentration camps, in war, during cataclysms, or in prisons when a person is waiting to meet the death penalty. In every place of pain the voice of prayer is the most pertinent and the most authentic. It brings out the confines of man which are usually ignored. The person who is healthy is usually instinctively led to think that he is self-sufficient and he does not realise that he is the victim of an illusion. It is suffering that tells us the truth and invites us to engage in prayer. It is said that it co-operates in the improvement of a person's state of health. And this is well said. However, even though it may not produce any result at a physical level it is always a great achievement at the psychological and spiritual level. It gathers man up and places him before God.

In praying we 'raise ourselves up above ourselves and above what surrounds us, and we carry our gaze into the distance towards a far off horizon, towards a sphere beyond time and space, a sphere full of greatness and clarity, but also of mystery'.[21] The sick person who prays precisely because he wants to rise above himself or herself, does not feel desperately caught up in the situation of crisis in which he or she finds himself. Despite the fact that the ground goes from beneath his or her feet he or she does not lose trust because he or she has a solid point to which prayer directs him or her. The world is not reduced to a world of injustices, violence and disasters. The praying person knows this and for this reason opens himself or herself up to a dialogue with God, in whose hands he or she places himself or herself. The sick person then becomes aware of his or her real being, which up to that point his period of health had been concealed.

Illness and prayer go well together. They are an experience of authenticity. Our human condition, threatened by nothing (Heidegger), finds its real character by opening itself up to invocation which gives a word to weakness and beginning from the bottom, from the humble situation of poverty, acquires its strength.

The infirm person is forced to enter into a relationship with the end.[22] In this sensitive difficult situation prayer enters the scene to keep that person still anchored to life. In essential terms it offers the prospect of salvation from death. Faced with death the instinctive reaction is flight – to close one's eyes to one's own fragility. Prayer blocks every attempt at evasion, it enables things to be called by their proper name, and in revealing their vanity opens up a breach to what is high above us. Those who pray are asked to engage in sincerity with themselves and sincerity is the clarity which reflects the world as it is without disguises. From the relative world it raises us up to the absolute world. In prayer there is what is above this world and the beyond, there is the whole universe in which the infirm person finds his or her place as a being loved by God. From this he or she draws hope and courage.[23]

Matthews has discovered in prayer a healing force which is beneficial for the organism itself. This, however, is only a consequence of a much more important order for the spirit which provides the right way of measuring man. Illness is not only required so that we can become healthy. The reality is much greater than this: if it teaches us to pray it is required simply so that we can become men.

Rev. MARIO BIZZOTTO,
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Notes

[1] See the text and commentary of the 'Nota' in A.BRUSCO (ed.), *Curate i Malati. La Pastorale della Salute nella Chiesa Italiana* (Ed. Camilliane, Turin, 1990).

[2] D.A. MATTHEWS, *Glaube macht Gesund. Spiritualità und Medizin* (German translation, Herder, Freiburg, 2000). On the same subject of faith and healing see the chapter by M. GOTTSCHICHN in his *Spracloses Leid* (Springer, Vienna-New York, 1998), esp. pp. 95-104.

[3] Cf. *ibid*., p. 32.

[4] Cf. *ibid*., p. 37.

[5] Cf. J. MEYER-SCHEU, *Seelsorge im Krankenhaus. Entwurf für eine neue Praxis* (Grhnewald, Mainz, 1974) and J. MEYER-SCHEU, *Seelsorge im Krakenhaus (1977)*, pp. 921-28.

[6] H. THIELICKE, *Leiden an der Kirche* (Furche, Hamburg, 1965), pp. 97-103.

[7] See on this point D. CASERA, 'L'Assistente Religioso nelle Istitutzioni Sanitarie', in A. BRUSCO (ed.), *Curate gli Infirmi*, pp. 125-134. And see above all M. Gottschlisch, *Sprachloses Leid*, pp. 39-44.

[8] H. FABER, *Der Pfarrer im Modernen Krankenhaud* (Ghterslosher Verlaghaus, Ghtersloh, 1970), pp. 13ss.

[9] Cf. V.E. GEBSATTEL, *Imago Hominis. Breiträge zu Personalen Anthropologie*, Mhller Verlag, Salzburg, 1968), p. 44, and V. FRANKL, *Ärztliche Seelsorge* (Kindler, Munich, 1975), p. 220. See also the criticism of Frankl in E. RINGEL, *Selbstschädigung durch Neurose* (Herder, Freiburg, 1973), pp. 208 and 238.

[10] Cf. *ibid*., pp. 240ss.

[11] Cf. V.E. GEBSATTEL, *Imago Hominis*, p. 31.

[12] D. CASERA, 'Visita al Malato', in *Dizionario di Pastorale Sanitaria* (ed. Camilliane, Turin, 1997), esp. pp. 1378ss, and A. Brusco, *Guaritore Ferito*, p. 47.

[13] Cf. V.E. GEBSATTEL, *Imago Hominis*, p. 47.

[14] Cf. *ibid*., p. 48.

[15] Cf. E. RINGEL, *Selbstschädigung durch Neurose*, pp. 235-248. On the relationship between the therapist and the religious assistent see the comments in V. FRANKL, *Ärztliche Seelsorge*, pp. 217-227.

[16] Cf. H. DIEDERICH, *Der Krankenbesuch* (Seelsorge Verlag, Freiburg, A.B., 1965), p. 6.

[17] Cf. A. Reiner, 'Seelsorger und Pazient', in *Lexikon Medizin, Ethik, Recht* (Herder, Freiburg, 1992), pp. 1004ss.

[18] R. GUARDINI, 'Der Dienst am Nächsten in Gafahr', in by the same author, *Sorge um den Menschen*, Vol. II (Wekbund-Verlag, Whrzburg, 1966), pp. 66-93, and H. THIELICKE, *Wer darf Leben?* (Goldmann, Munich, 1970), pp. 146-151. On the subject of humanisation see A. BRUSCO AND S. PINTOR, *Sulle Orme di Cristo Medico* (EDB, Bologna, 1999), esp. pp. 161-169, and above all P.L. MARCHESI, 'Umanizzazione Sanitaria', in *Dizionario di Teologia Pastorale Sanitaria*, pp. 1327-1340. I would like also to refer to a very well organised study; C. CASALONE, *Medicina, Macchine e Uomini* (Gregorian University Press, Morcelliana, Brescia, 1999), esp. pp. 43-48 and 292ss.

[19] Cf. L. SANDRIN, 'Nella Vigna del Signore anche il Malato Deve Lavorare', in A. BRUSCO (ed.), *Curate i Malati*, pp. 107-125.

[20] Cf. H. DIEDERICH, *Der Krankenbeseuch*, p. 17.

[21] E. MINKOWSKI, *Il Tempo Vissuto* (Italian edition, Einaudi, Turin, 1971), pp. 105ss.

[22] Cf. *ibid*., p. 108. See also the question of prayer and suffering as approached by G. MORETTO in his incisive work *Giustificazione e Interrogazione. Giobbe nella Filosofia* (Guida, Naples, 1991), esp. pp. 199-207.

[23] Cf. D.A. MATTHEWS *Glaube macht Gesund*, esp. pp. 202ss and 256ss. On the same subject see also E. Bianchi, 'Preghiera', in *Dizionario di Teologia Pastorale*, esp. pp. 932-936.

MICHAEL D. PLACE

II: The Hospitals of the 20th Century: Ancient Charity and Modern Technology

Before addressing the topic I have been assigned, "How hospitals in the year 2000 are to respond to the technological and other challenges before them", allow me a word about Catholic health care in the United States. The ministry began some 223 years ago in New Orleans founded by "the Ursuline Sisters." From that humble beginning it spread across the emerging nation. Through the efforts mostly of religious women and men, often coming to the United States to serve the immigrants from across Europe, health care was provided to those who otherwise would have been without. Today there are over 600 Catholic hospitals, over 700 long-term care facilities as well as 700 other expressions of Catholic health care delivery. Each year one out of six patients admitted to a hospital in the United States enters a Catholic hospital. Often we are present caring for the poor and the marginalized where others will not go or do not stay. Increasingly we also are working with our colleagues in Catholic Charities and other church ministries to better serve the particular church and local communities. The bishops of the United States affirmed and gave direction to the ministry in their 1981 Pastoral Letter, *Health and Health Care*. We also were deeply honored when His Holiness, Pope John Paul II, during his second pastoral visit to the United States, spoke to a gathering of health care leaders from across the country. It was in his remarks that he declared: "Health care is an essential ministry of the church."

Current Situation

Like so many of you this "essential ministry" in the United States is facing daunting challenges in addition to those that arise from technology. Allow me to mention a few:

Funding: The continuing attempts at the state and federal level to contain government expenditures for health care as well as the fiscal constraints emerging from the realignment of private insurance through managed care have challenged the financial stability of the ministry.

Labor: The combination of significant pressure from labor unions and other forces to significantly increase salaries as well as the emergence of a critical short supply of nurses and other health care professionals puts an incredible strain on the delivery system.

Consumerism: The expansion of access to the Internet with its wealth of medical and other information has resulted in a more informed and pro-active patient/consumer. More and more a patient arrives armed with a self-diagnosis and treatment options. They also "shop" physicians and providers based on available information from various public rankings of quality, etc.

Genetics: Similar to previous revolutions in health care delivery that resulted from the discovery of anesthesia and penicillin, as well as the current revolution in practice patterns associated with remarkable achievements is pharmacology (i.e., designer drugs), we are at the cusp of a new revolution that will result from the mapping of the human genome. Genetics and cell research will fund an entirely new way of practicing medicine and delivering health care.

The result of these challenges and those of technology is that the very face of Catholic health care has changed. The hospital which in recent times has been the center of health care delivery today often is described as a dinosaur: A relic of the past that stands in the way of a vibrant future. Patient health care increasingly is provided along a "continuum of care" that includes ambulatory care centers, freestanding diagnostic services, rehabilitation centers, outpatient surgery programs, home care services, assisted living, long-term care, and hospice. Social services often are needed to help, especially in the hospital setting, the patient and family plan for and access the services they will need once discharged from the hospital. There also is an expanding attention to what are described as "alternative forms" of medicine such as massage therapy, acupuncture, and herbal therapy. The relationship of spiritual care to successful physical recovery is an emerging field of study and service. Even as these changes cascade across the landscape of the ministry, the role of the physician is both challenged by the fiscal demands of managed care and made more important because there is no effective continuum of care without partnerships with physicians, nurses, and other practitioners.

The result of these and other

forces is that the ministry can easily become bureaucratic, fragmented, and impersonal. A word on each:

Bureaucratic: Both public and private insurance and providers have been forced to develop an abundance of regulations and forms that confuse and anger patients and their families.

Fragmented: Even as the understandable evolution of other-than-hospital forms of delivery have developed, these emerging dimensions have lacked coherence or cohesiveness. The physician at times has been reduced to just another "cog in the wheel" with the result that patients, if they are to successfully navigate this fragmented terrain, must become their own advocate. Obviously this is a task easier to accomplish for the "near healthy" than the critically ill or socially vulnerable.

Impersonal: The end result is that the face of health care delivery can be quite impersonal. Once noted for the "hands on" care of women religious, Catholic health care is challenged not to be the same as secular health care. Despite the best of intentions, this is increasingly difficult when the length of the encounter is marked by minutes and hours, not days or weeks. Similarly the patient often is viewed in isolation rather than as a member of a family or part of a community.

Inspiration:

Clearly these adversities when combined with the post modern world fascination with the technological imperative*: if it can be built, build it; if built, buy it*, puts Catholic health care delivery in the northern First World in a difficult situation even apart from the unaddressed reality that the United States and the other industrialized nations consume an inordinate amount of global health care resources.

In this environment, despair, cynicism, and skepticism easily can take hold. As an antidote we need only turn for inspiration and motivation to those monks who despite the limitation of the Dark Ages staffed the monastery infirmaries, or to hospitallers of St. John of God who cared for Christian pilgrims in times of great adversity. Despite the insurmountable odds they faced, they carried on and, indeed, flourished. Why? Because long before John Paul II enlightened us with the image of the Gospel of Life, they practiced the Gospel of Life. They saw in the vulnerability of each human being an inalienable sacredness of life as well as an unbreakable bond of solidarity that made them part of the community that is the human family. And the source of their inspiration for being servants of the Gospel of Life is none other than the image and reality of Christ healing or, in other words, the healing Christ. Clearly the soul of what in the United States we speak of as "the healing ministry" is to be found in the multiple Gospel stories of Jesus healing the lame, the blind, and the leper as well as the ultimate healing of restoration to life.

If the healing Christ is the soul of the ministry, then I would suggest it is to the healing Christ that we should turn to seek guidance as to how we might best respond to the technological and other challenges we face. To that end, Father Donald Senior, CP, recently offered a reflection on three different modalities we find when we study the Gospel stories of the healing Jesus: liberation, solidarity, and hope. I will utilize these modalities as a basis for my reflections on how Catholic hospitals and, indeed, all of Catholic health care can and should respond to the current challenges.

Liberation:

Father Senior posits that in the first instance Jesus came to free people, in the context of a faith response, from sickness and illness. And, as so often is the case in the Gospels, he reversed the customary religious and cultural expectation that sickness was a sign of personal failure or divine judgment as well as the justification for the alienation or separation seen so visibly in the case of the leper, or the woman with the hemorrhage, or the irritating lunatic confined to caves outside of town.

Catholic health care in the United States has consciously decided that it too must be about liberation. It finds itself called, indeed compelled, to be an agent of social transformation that like Christ reverses the contemporary assumptions and biases that isolate and alienate those who are sick or whose health status is threatened. Three examples.

Environment: In recent years a body of data has been developed that clearly demonstrates a causal relationship between environmental toxicity and diminished health status. Though the exact nature of the linkage in many instances is yet to be determined, the causal relationship is not in question. For example, especially disconcerting is the dramatic increase in the incidence of asthma and related pulmonary problems among the young, especially the poor.

At the local level Catholic providers have developed programs that, while treating the asthmatic or pulmonary conditions, also work to remove environmental threats either in housing stock or in local hazards such as toxic waste sites. On a more national level, health care systems utilize their financial investments in a "socially responsible" way to advance stock holder resolutions that will reform detrimental corporate policy on matters such as the use of mercury as well as advocating for state and federal policies to enhance air and water quality.

Social Conditions: It is not surprising that for a person without access to housing, it is difficult, if not impossible, to have a positive health status. Similarly, inadequate nutrition, drug and alcohol addiction, and mental illness are directly related to diminished health. Though made more difficult because of an increasingly fragile financial condition, Catholic health care delivery has moved into the community to address these problems. Working, often in partnerships with others, Catholic health care labors to provide affordable housing, often for the elderly, to establish communi-

ty outreach centers that in addition to making available on-site meals also provide "meals on wheels" to the homebound as well as providing outpatient services and support for those with addictions and mental health challenges. In all of these efforts Catholic health care seeks to free people from the shackles of marginalization by providing services and supports that both respond to their sacred dignity and draw them back into the community.

Government Policy: Perhaps the most inexcusable restraint on a positive health status for persons in the United States is the lack of access to health insurance. It is a moral outrage that in the wealthiest nation of the world nearly 44 million persons currently are without insurance and consequently excluded from access to the full range of health care services. It is especially lamentable that 10 million of the uninsured are children who are reduced to receiving their health care in the emergency room.

In response to this reality, Catholic health care has been, and will be, an aggressive advocate not just for access to basic health care but for a reform of the entire health care system so that accessible and affordable health care for all will be provided in a delivery system that is marked by quality, safety, justice, and compassion. This is accomplished through the credibility of our presence as a "voice for the voiceless," by encouraging our 800,000 employees and their families to use their ballot as an instrument of change, and by being present to the White House, the Congress, and the state legislature. Working without the benefit of "miraculous power," we are committed to our goal of social transformation.

Solidarity:

Personalism: Even as Jesus broke the bonds of illness, he did not eliminate all the human suffering that comes with sickness and pain. The one who suffers often experiences a sense of isolation or separation. This isolation stands in stark contrast to the true solidarity that should be a mark of a human community that reflects the communal nature of the Triune God in whose image and likeness we are made. As Jesus traveled the Holy Land he witnessed to that solidarity as he ate with sinners, cured the centurion's servant, and worked miracles among the Samaritans. Similarly that same solidarity of spirit was exemplified when he wept with Lazarus' family. Perhaps the most profound witness of solidarity with those who suffer was pointed out again by Father Senior when he reminded us that the body of the glorified Jesus continued to bear the wounds of his suffering and death. Even in glory Jesus remains one with those who suffer.

In modern times perhaps our most vivid reminder of this solidarity is Mother Theresa and her community. From the streets of Calcutta to the boroughs of New York she and her sisters have washed, fed, and carried the sick and the outcast in a silent testimony to the solidarity of the human family.

Clearly that same spirit must be a hallmark of the many and varied expressions of the Catholic healing ministry. If we are to heal as Jesus healed then both literally and metaphorically we must touch as Jesus touched the human body, mind, and spirit. "High technology" without "high touch" is lacking the solidarity that is at the essence of our ministry. Without a doubt this restoration of an authentic personalism to the doctor's office, the emergency room, the surgical suite, and patient room must be accomplished. The obstacles, as noted earlier, are numerous. And I wish I could share with you some dramatic examples of success. Unfortunately, I cannot. We have a long way to go. But we are moving. Physicians more and more are speaking out against the structures of managed care that require them to allocate but a few minutes per patient no matter their physical, emotional, or spiritual condition. Administrators are developing programs whereby a patient or family member can call attention to an employee who has given exemplary "personal" care. And governance bodies are using "patient satisfaction" as one of the critical components in determining executive compensation.

All good beginnings, but so much more must be done.

Allocation: Before closing this section I want to make note of, albeit briefly, of another challenge to an authentic sense of human solidarity. Even as we have failed on the macro or universal level to have an appropriate discussion about the allocation of the world's health care resources, in the United States, and I suspect elsewhere, we also have failed to engage in systematic and informed discourse about a national health

care policy that would provide for a fair and equitable distribution of limited health care resources.

The Roman Catholic tradition, I would suggest, compels us to work for and participate in such a discussion. We are informed by an understanding of human solidarity that, as Blessed Pope John XXIII taught us, understands access to fundamental health care to be a human right and consequently, also, as a social good — social good that speaks to the existence of interlocking personal, social, and governmental responsibilities to preserve and ensure the realization of that same social good. Absent such a discussion, the increasing cost of health care delivery, fueled in no small measure by the escalating costs associated with "high tech" as well as drugs, has led to what, in fact, is an indirect or implicit process of allocation. The absence of insurance is one example of such an indirect allocation. Significant variance in practice patterns and health care outcomes according to race, gender, and geography are indices of other implicit patterns of allocation. Another is the decisions made by health plans, or the employers who purchase them, as to what will be covered. An example is the limitations frequently placed on behavioral health benefits. At other times, allocation decisions have been made by Congress or state legislators when they mandate coverage of services such as fertility treatment.

While the reasons for the continuing attachment in the United States to this "implicit allocation" is fueled by multiple factors (such as a capitalistic belief in the power of the market and a fear of "big" government) on a more theological level it is fed by an unnuanced understanding of the individual and an impoverished sense of human solidarity.

Though clearly affected by these larger cultural forces, Catholic health care, most especially in those countries where it has a significant social presence, must be an aggressive participant in the social discourse that can lead to a more rational and just distribution of health care resources. Nurtured by a coherent moral vision and a profound sense of the interlocking and interdependent obligations and responsibilities of human solidarity we can help to bring about the needed conversations.

Last year in a lecture at the Catholic Theological Union of Chicago, building on work previously done by the Catholic Health Association, I offered some initial reflections that might well serve such a discussion. I began by noting that this is a quite complex issue. Currently, 13.5 percent or $1.1 trillion of the U.S. Domestic National Product is spent on the various aspects of health care. Just 18 years ago, it was 8.9 percent of the DNP. Such an increase raises the question: Should there be any limit on these expenditures and, if so, how as a nation would we make such a determination? For example, should how much we spend on health care be determined simply by market forces or by federal mandate, or some other source? And if such a decision should be made, what would be the criteria that would guide such a decision-making process? For example, is national defense more important than the nation's health? If so, by how much? As if those questions were not complex enough, I pointed out that there is the parallel issue of how we allocate the existing resources, the $1.1 trillion dollars, in a just and equitable manner.

I noted that in recent years, there have been various proposals in the United States to develop more explicit criteria for allocating health care resources. Perhaps one of the most famous of these took place in Oregon, which received a federal waiver to develop a statewide health system for those on Medicaid with a guaranteed "basic benefit package" set by state policy. In other words, it was proposed – and eventually adopted – that those whose economic status qualified them for Medicaid would be guaranteed a range of services and also would be explicitly denied some treatment options.

Although there have been no other recent examples of as public a discussion of resource allocation as there was in Oregon, I suggested it remains an important, if not well articulated, issue. In fact, if the efforts of groups such as the Catholic Health Association and others to make accessible and affordable health care a national priority are successful, how we allocate health care resources will require attention.

Such a conversation will not come easily. Allocation is often taken as being the same as rationing, and the concept of rationing does not sit well with the popular sense of America's dedication to a certain understanding of liberty that is presented in American ethics.

As we consider either the necessity or the eventuality of a discussion of how we allocate health care resources, I suggested that the prism of the consistent life ethic will be of assistance. For example, our rich understanding of human dignity would require any discussions of allocation to be applied equitably and free of discrimination because of our shared human dignity. Similarly, because access to adequate health care is a fundamental human right, there is a baseline of services that cannot be subject to political trade-offs. That same inalienable dignity would require an open and participative process that involves all those affected by allocation decisions. Turning to the stewardship of human life and resources, any allocation must have an ethical priority ensuring that the provision of these resources are provided to the disadvantaged. Good stewardship also requires there be a demonstrated need for allocation decisions or processes and that the social and economic effects of allocation decisions be monitored to see that they reach their stated goals and do not have unintended consequences.

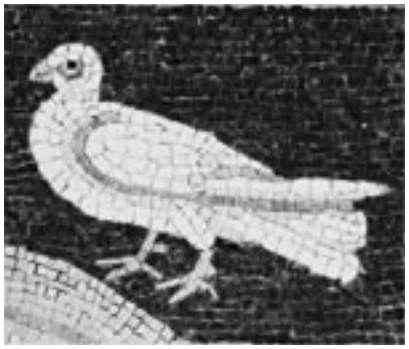
Finally, an integral understanding of the common good will provide an important framework for decision making. It will require that allocation decisions focus not just on individuals but also on the health status of communities and those social forces that can better enhance personal and communal health. A rich understanding of the common goodwill change

limited understanding of human liberty that would assert that individuals should be able to receive whatever health services they desire even if, medically speaking, those services are considered futile.

Hope: So far in our reflections we have reviewed the current technological and other challenges facing Catholic health care in the United States and considered how, inspired by the Gospel stories of the healing Christ, Catholic health care is responding from the perspective of liberation and solidarity. In his writing Father Senior identified a third modality which for my purposes I will speak of under the title "hope".

As believers we are quite aware of the essential relationship between body, mind, and spirit. In fact, in these reflections we dealt with one aspect of that relationship when we spoke of the sense of separation from community that can be associated with sickness and illness. In the final section I want to reflect on another consequence of illness, most especially debilitating chronic illness or terminal illness. Both most often carry with them a deep and, at times, a devastatingly profound alienation of the human spirit. As bodily energies drain away or are permanently depleted the normal harmony of body and spirit comes to an end: the customary relationship with physical surroundings is altered; interpersonal relations are changed and, in face of death, near an end as we know them. And often the result of all this is a sense of alienation within the human spirit itself from the sources of meaning or purpose that had served as the *raison d'être* of an individual's existence.

To all these forms of alienation, and most especially to the alienation of spirit, Christ the healer came. Answering once and for all the lament of Job, Christ through his death and resurrection gave to humankind his greatest healing gift – hope. It was to this hope which Joseph Cardinal Bernardin turned, even as he was facing the personal challenge of pancreatic



cancer, as the leitmotif for Catholic health care. Allow me to quote:

"Let me be clear what I mean by "hope." It is not a hope for something. It is not the expectation that something will happen. Although some people hope for a physical cure, not everyone does. Often people believe that a cure is not possible, or they are too tired to hope to be restored to their former state of health. But, even when a cure is not to be expected, one can still hope. The hope of which I speak is an attitude about life and living in God's loving care. Hope, rooted in our trust of God's love for us in Christ, gives us strength and confidence; it comforts us with the knowledge that, whatever is happening to us, we are loved by God through Christ. So, we need not grieve or despair in the same way as those who do not share in this hope (1 Th 4:13-18). Illness need not break us. Even if we remain ill, even if we are to die prematurely, we can still be courageous and confident of God's enduring love for us (2 Cor. 5:6-10).

As Christians, we are called, indeed empowered, to comfort others in the midst of their suffering by giving them a reason to hope. We are called to help them experience God's enduring love for them. This is what makes Christian health care truly distinctive. We are to do for one another what Jesus did: comfort others by inspiring in them hope and confidence in life. As God's ongoing, creative activity in the world and the love of Christ make it possible for us to continue to live despite the chaos of illness, so too our work in the world must also give hope to those for whom we care. Our distinctive vocation in Christian health care is not so much to heal better or more efficiently than anyone else; it is to bring comfort to people by giving them an experience that will strengthen their confidence in life. The ultimate goal of our care is to give to those who are ill, through our care, a reason to hope".

It is no wonder that this vision has found a deep resonance within Catholic health care in the United States. Truly we are called in a profoundly pluralistic society to be, as the Cardinal said, a multifaceted "sign of hope." For our fellow Christians we are a living witness to the ever hopeful Easter Alleluia; to the one who believes in a good God, we are a living testimony to a gracious, but as Paul said in the Acropolis, yet unnamed God; and to the one who believes not, we offer the experience of a transcendent power of the spirit that can draw one beyond human limits to an ultimate sense of benign purposefulness.

Indeed, to be such a "sign of hope" is a daunting responsibility especially in light of all we have noted. But a challenge we avoid at great peril. I say this because liberation and solidarity without the hope that is essential to the Christian faith can easily become nothing more than a well-intentioned political movement or an enlightened form of psychosocial therapy.

For Catholic health care to be a "sign of hope" is to make its own the evangelical dimension of the healing ministry. While we honor the conscience of those we serve and never use our ministry to proselytize, ultimately through experience, witness, and testimony we are hope-filled evangelists.

Even as I say this, I am aware of the difficulties. In the United States as there are fewer religious women and men in the ministry and the laity assume legitimate leadership roles in fulfillment of their baptismal responsibilities we must find new ways to nurture a rich and vibrant faith-filled culture across the continuum of our services. With co-workers who increasingly are not Christian and a patient population equally diverse we need to make explicit our commitments and values.

And in a society profoundly conflicted about the sacred nature of unborn life and now debating the legalization of euthanasia we must be faithful servants to a consistent ethic of life.

As I move about our country and visit the richness of the ministry we steward I am optimistic about the future. And that optimism has two sources: first, and most importantly, the Gospel promise *"I will be with you always"* and, second, the inspiration of the religious communities that founded and remain present in various ways to the ministry. For example, if rooted in the simplicity of Francis of Assisi, the hospitality of Mother McCauley, and the inventiveness of Vincent de Paul and Louise de Marillac, how can we fail to meet the challenge of technology and the many others we have noted?

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ANTHONY FISHER

III: The New Frontiers

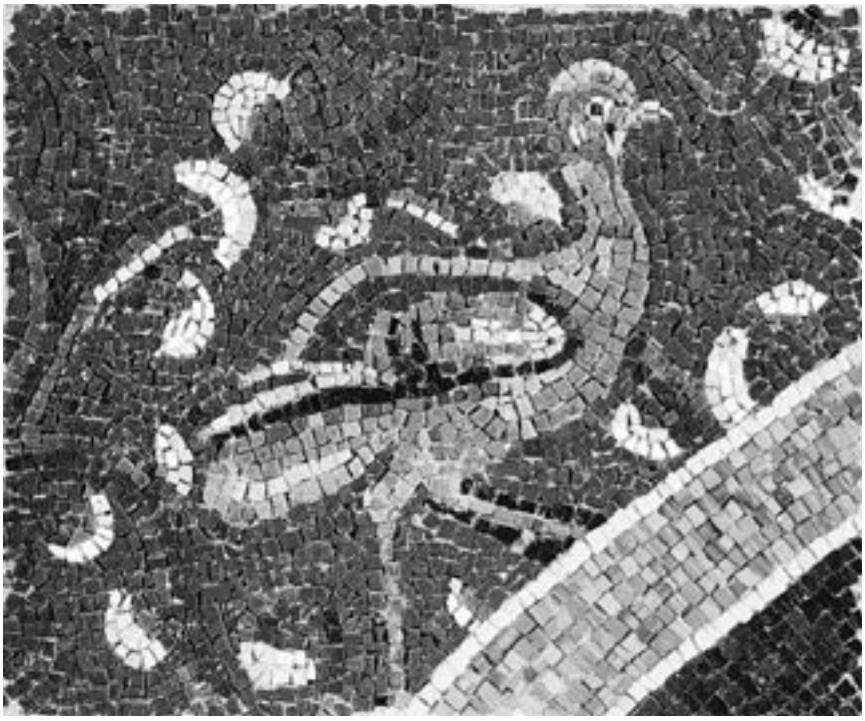
1.Introduction

A few years ago I met a young couple who had had some terrible news: their unborn baby was severely handicapped. He had anencephaly in fact, and as soon as it was diagnosed their 'Catholic' doctor at a Catholic hospital proposed that the baby be aborted. The doctor called it 'induction' and explained that it would be performed at a non-Catholic hospital. The couple 'smelt a rat' (= were suspicious). Short of a miracle they knew their baby's life would be brief, yet Clare and Tom were determined to see their pregnancy through and give their little boy every chance. They approached the forthcoming birth with all the excitement and apprehension of new parents, but without the expectation that most have, that their child will be healthy and will outlive them. They found a new doctor and a different Catholic hospital, and that place proved a refuge for them and their little baby.

Buoyed up by faith, family and friendship, this young couple still found the vigil of their pregnancy a terrible strain. Yet they were determined to resist the pressures of their surrounding society to write off the life of their little one as nothing, indeed less than nothing, a negative value on the quality-of-life accounting scale. They approached the future with apprehension but hope, with common sense and love.

Their little boy was born at the hospital and immediately baptised 'Thomas Walter' by his father; when I arrived I confirmed him. He lived another eighteen hours. He had a beautiful little face and a perfect little boy's body; his heartbeat was strong and he breathed easily; but his head was incomplete and his fate therefore sealed. Occasionally he made little sounds and would hold tightly onto someone's finger with his little hands. His parents fed him little drops on the end of a finger. Grandparents, uncles and aunts, gathered from various parts of the region to visit little Tom, to touch him and be touched by him, to know him a little bit and share in his short life and his parents' joy and tears. Every moment of his life he was held tightly by someone who loved him. He packed so much into his eighteen hours. It was long enough to have his clothes changed several times and to be hugged and kissed and stroked. Long enough to give Clare and Tom some time with him, to celebrate little birthdays as he achieved each new hour and especially their private one with him at midnight when, against all the odds, he saw in a new day. He even gave them a night of disturbed sleep with their child, which is every new parent's right. And he gave them time to say goodbye.

Before I left on the night of his birth we prayed the prayers for the dying for him. Around dawn little Thomas died as he slept between his parents in the hospital. We gathered again, his parents and grandparents, this time to pray the



prayers for the dead and to pray for those who grieve them. Everything possible had been done for him by his parents, extended family and friends, by his health professionals and chaplains. Together they gave the most powerful testimony to the Gospel of Life, to the preciousness of human life; together they demonstrated the nobility that even so great a tragedy can call forth from the spirits of ordinary people; together they wrote a love song with their lives...[1]

In this conference speakers have drawn our attention to the enormous range of new possibilities in healthcare in the new century, of new questions which these technological possibilities pose, and of new answers which might be given. All of these present enormous challenges to Catholic healthcare institutions and professionals, and thus to the Church not just as the provider of healthcare services, but as pastoral carer for both patients and healthworkers.

2. Healthcare today: on three frontiers

Healthcare and chaplaincy today find themselves on three frontiers: between a view of healthcare as a vocation and a view of it as a merely technical achievement or market product; between a consequent view of healthworkers as professionals and saints-in-the-making and a view of them as mere technicians or service–providers; and between a view of individual healthcare practices and choices as activities with their own proper goals and subject to common morality and a view of those practices and choices as bound only by the limits of the possible. It is these three frontiers that I wish now to explore.

2.1 On the frontier between "healthcare as a vocation" and "healthcare as a technical achievement or market product"[2]

When God came among us in Jesus Christ he redeemed humanity not only by his saving death, by preaching his saving word, by absolving sins, by gathering us into a new people of God, but also by curing people. Matthew tells us, "Great crowds came to him, bringing with them the lame, the maimed, the blind, the mute, and many others. They put them at his feet, and he cured them, so that the crowd was amazed when they saw the mute speaking, the maimed whole, the lame walking, and the blind seeing. And they praised the God of Israel."[3]

Just as Jesus' healing miracles at once expressed the healing compassion of God *and* provided signs and foretastes of the coming of God's kingdom, so Catholic healthcare providers and professionals "see their ministry not only as an effort to restore and preserve health, but also as a *spiritual* service and a sign of that final healing which will one day bring about the new creation that is the ultimate fruit of Jesus' ministry and God's love for us".[4] Even in the best secular tradition medicine and nursing are about far more than just technical excellence or the fulfilment of market demand. All the more so must *Catholic* healthcare testify to beliefs about a loving, provident God, about creation and human nature, about sickness and death, the communion of saints, the forgiveness of sins, the resurrection of the body, and life ever-lasting...[5] Our faith means we see the person as much more than a special kind of intelligent animal or machine determined to get its own way, able to attain to certain technically impressive achievements, or producing and consuming goods and services: the human person is the image of God and the human community is the image of the Trinity. We *are*, indeed, brothers and sisters in the Lord and we are our brothers' and sisters' keepers; familial love, reverence, wonder, what St Thomas called *dulia*,[6] this attitude should mark our relating. Embracing the whole person – body, mind and spirit – with compassion and love, Catholic healthcare says to people, "As Christ would reach out to touch and heal you, so too do we."[7]

How that will pan out in day-to-day healthcare in our new century is not easy to predict: perhaps in the courtesy and compassion, the patience and perseverance, the vigilance and hopefulness, the willingness to engage in apparent inefficiencies such as standing by and listening, a reverential language and touch and awe not unlike that with which we treat the holy things. And words like 'vocation', 'mission' and 'apostolate', which roll so easily – too easily – off the Christian tongue,

must mean more than 'job' or even 'profession' here: they must bespeak a kind of priestly ministry of mediating and praising the God who is the lover of life and health.[8]

If Catholic healthcare is conceived as a religious vocation, those charged with it must be wary of secularization, accommodation and compromise to the logic of the merely technical achievement or market demand,[9] and wary too when medicine exceeds its legitimate sphere, colonizing the whole of reality, promising to alleviate people of the human condition, offering them false hopes of earthly immortality, engaging in therapeutic overkill, pretending health is salvation. Worshippers of true religion must always be ready critics of healthcare messianism, therapeutic obstinacy and idolatry of life and health.[10] Health is not our highest good and healthcare is not our religion.

Jesus healed whole persons, body and soul. When he cured the paralytic he first forgave him his sins.[11] The links between physical and spiritual sickness, and physical and spiritual healing, have long been appreciated by Christians and other believers. As the US Bishops have observed, "without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person. Directed to spiritual needs that are often appreciated more deeply during times of illness, pastoral care is an integral part of Catholic healthcare."[12] Catholic pastoral care to the sick is different from social work, counselling, other human supports, even if it includes elements of these things: it is first and foremost about the sacraments.[13] But this presents particular challenges today. The shortage of priests, lay chaplaincy teams including people of various backgrounds and perhaps some interns, a mixed bunch of patients, shorter stays: all this presents new opportunities but it can also lead to a de-sacramentalisation of that ministry. Yet the sacraments of anointing of the sick, confession, communion and viaticum for the dying – these must remain central to any genuinely *Catholic* form of healthcare. And there need to be regular opportunities for communal prayer and worship, both for patients and staff. Obviously such spiritual care, like the rest of healthcare, will have to be tailored to the particular needs of patients and staff: non-Christians, non-Catholics and non-practising Catholics, for instance, will have very different needs to more 'regular' Catholics. None the less even non-Catholics come to our institutions as patients or staff expecting a distinctively 'spiritual', unembarrassedly Christian, approach, and we ought not to be afraid that 'showing our Catholic petticoats' will offend outsiders.

In addition to the sacraments, pastoral care to the sick "encompasses the full range of spiritual services, including a listening presence, help in dealing with powerlessness, pain and alienation, and assistance in recognizing and responding to God's will with greater joy and peace".[14] The goal here is to confirm brothers and sisters in the Lord so that they might live, suffer and die well. Seeking to humanize and Christianize sickness, dying and healthcare technology itself, and offering cause for hope even when medicine can do no more, are crucial ways in which pastoral care complements clinical care.[15] In the case of Clare and Tom, pastoral care and the support of family and friends were crucial supports in their heroism: without these I do not know how they could have made the journey to their child's birth.

2.2 On the frontier between "healthworkers as professionals and saints-in-the-making" and "healthworkers as technicians and service providers"

Parallel to the frontier between healthcare as a vocation and healthcare as a mere technical achievement or market product is the frontier between two different conceptions of the healthworker: on the one hand, conceived of as professional and indeed a saint in the making; and, on the other hand, conceived of as a mere technician, a service provider, even a hired gun. 'Profession' is properly an ethical notion entailing much more than does the idea of a job, a trade or an art: a conviction on the part of members about the importance of a particular service of others and their 'calling' to it as 'full-time' occupation with enduring expectations; immersion by those members in the particular practice, with its particular knowledge, skills and ethos, which calls forth and requires from them devotion of life and character and life; some kind of public profession of a 'service orientation' and public responsibility by the members; some parallel act(s) of public recognition by the community that this practice is an expression of its core values and that these people are suitable practitioners; continuing (self)regulation by the members of the profession according to the internal ends of the practice and the best traditions of ethics.

The call to be saints, which is the call of every Christian health professional, is a call not in conflict with the demands of professionalism but rather to be more than a tradesman, more even than a professional: it is a call to a Christic kind of self-giving told so wonderfully in our tradition in the image of Christ the physician, in the story of the Good Samaritan, and happily in many saintly health professionals we have known. To attain to such heights is not beyond the grasp of ordinary healthworkers: on the contrary it is their very calling. But it does require a spirituality of the healthcare vocation and a genuine effort to cultivate a certain kind of character marked by respectfulness, pietas, compassion, understanding, benevolence, spontaneity, honesty, fidelity, thoroughness, patience, moderation, humility.[16]

Leaders and staff of Catholic hospitals should therefore be especially wary of the institutionalization of vices such as cavalier disrespect for human life and dignity, blindness or indifference to effects of policy on particular people, avarice and ageism, the technological imperative, and so on.

They must resist the sacrifice of persons for the sake of efficiency, progress or profitability, and promote a certain asceticism in response to the drive to medical maximisation, and a certain contemplativeness in response to the busyness of the average hospital. Associations of Catholic health professionals, moribund in many countries for the past two decades, might usefully be refounded with a clearer focus on ethical and spiritual formation and support for healthworkers possibly little catechised or facing external pressures to conform to the values of 'this world' rather than those of God's kingdom.

2.3 On the frontier between healthcare practices as "activities with their own proper goals and subject to common morality" and as "activities as bound only by the possible"

In his programmatic reading from the prophet Isaiah at the beginning of his ministry, Luke's Jesus declares himself anointed by the Holy Spirit both to preach the Gospel to the poor and unfree, and to bring healing to the blind.[17] "Jesus," we are told by Matthew, "went about Galilee, teaching in the synagogues, preaching the gospel of the kingdom, and healing every disease and infirmity among the people."[18] Sometimes the healings preceded and evoked faith; at other times the cure was a response to faith. Thus Jesus' prophetic work of preaching was intimately related to his work of healing. The linking of these two ministries is extended to his disciples: "As you go," he tells them, "proclaim the good news that the kingdom of heaven is at hand. Heal the sick, raise the dead, cleanse lepers, cast out demons."[19] Whether for Jesus or for his disciples, healing and preaching are, as it were, two sides of the same redemptive coin.

Catholic healthcare, then, must be *prophetic,* a lived proclamation of the Gospel. The very first footnote in the *Charter for Health Care Workers,* I am pleased to say, refers us to Pope John Paul II's address to health professionals at the Mercy Hospital in my home city of Melbourne, where he emphasized that healthcare is first and foremost "a very valuable service to life" but also "a form of Christian witness".[20] We are challenged today to renew our appreciation of healthcare as heir to a particular tradition – the noble wisdom of Hippocratic medicine – with its own internal ends and logic, and subject like all human activities to the norms of common morality;[21] to renew also our sense of *Catholic* healthcare as heir also to a revealed tradition, articulated

in Scriptures such as that of the Good Samaritan, and clarified in a tradition including such priceless works as *Evangelium vitæ* and the *Charter,* and applied through the charisms of particular founder congregations and their lay collaborators.

In recent decades there have been enormous ethical challenges for those committed to continuing the healing ministry of Jesus, not least the pressures of secularism, bureaucracy and the market, and the perennial temptation to 'jump into bed with the *zeitgeist'*. We must therefore be crystal clear what our central commitments are: respect for the dignity of every human person as made in the image of God, redeemed by Christ and made to enjoy the eternal joy of the Trinity and the saints in heaven; reverence for every instance of human life from conception to death as a sacred trust; love of neighbour and of the common good, including a passion to ensure universal access to a reasonable level of care and the just allocation of resources; respect for the nuptial significance of the body; a desire to humanize medical practice; and a preferential option for the disadvantaged.[22] This runs quite contrary to the view of healthcare practices and choices as activities bound only by the technically and politically possible.

Catholic healthcare is prophetic the more consistently and luminously it exemplifies these Christian values and norms; it obscures and ultimately abandons its *raison d'être*, the muter and more compromised is its moral witness. In recent years Church leaders have repeatedly recommitted the Church to healthcare, but also insisted that this must be in accord with sound morality as articulated by the best of the Hippocratic tradition purified by the Gospel and the Church's Magisterium.[23] Increasingly in the 'post-Christian' Western world, at least, Catholic healthcare should offer a stark alternative of a training and style of care in accord with our particular tradition and ethos. We should not shy away from this, for fear of losing funding or respectability. Indeed, I suspect that it is precisely as a high-quality *alternative* to the run-of-the-mill that Catholic healthcare will best be able to justify continued tolerance and support of funders, regulators and professions in the future. Unashamedly Catholic codes of ethics and practice, ethics committees, staff education programmes etc. will not only help ensure that Catholic health services fulfil their primary mission of providing sound care but also offer them a 'market niche'. This will have its attractions not only for many patients but also for many staff: for it is already the case in some parts of the world that trainees and practitioners in certain specialties such as obstetrics-gynæcology, family planning, genetics, pædiatrics, gerontology and intensive care, are pressured to conform to immoral practices and even refused positions if they will not. Without gen-

uinely Catholic healthcare institutions in which to train and work, some healthworkers might either compromise their consciences and objective morality, or have to quit their specialty. And without a clear sense of the boundaries – the frontier – between healthcare practices seen as activities with their own proper internal logic and subject to common morality and healthcare practices seen as activities as bound only by the technically, politically and financially possible, such perseverance in the pursuit of the good will be impossible.

3. The future of healthcare: on three more frontiers

We are witnesses to a biotechnological revolution probably more significant than industrialization, the atomic age, computerization. Recent advances in biology and medicine mean we are rapidly acquiring the power to modify and control when and how we come to be, when and how we die, and our very natures, capacities and activities in the meantime. Healthcare will in the future find itself increasingly on three new frontiers in addition to the three I have already outlined: the frontier between life and death in the womb; the frontier between respect for the dignity of the person and the commodification of persons; and the frontier between natural death and medicide. It is these three frontiers that I wish to explore in what time is left to me this evening.

3.1 On the frontier between life and death in the womb

At both ends of life the Christian vision of respect for every human being however vulnerable or strong, however wanted or unwanted, however suffering or well, is especially under pressure today and will continue to be so in the foreseeable future. Catholic health institutions and professionals are world leaders in the care of little ones, the tiniest, most vulnerable, of human beings, and of course their mothers. We have taken something of a 'preferential option' for the unborn and the newborn. That has plenty of support in our theological tradition, dating to the psalmist's rejoicing in the child knit together in his mother's womb, and Jesus' delight in having little children brought to him. And medicine today can do much that is life-affirming with respect to early human life. But newly conceived and newly born human life is not universally welcomed and in the future we will have more and more to decide whether to give sanctuary for such little ones.

Consider the new genetics.[24] We naturally rejoice in the extraordinary achievement of the human genome project and other activities which have contributed so very much to our understanding of the genetic basis of the human condition and which are so pregnant with therapeutic possibilities. Prudent therapeutic interventions aimed at correcting genetic diseases and preventing their occurrence or onset are in principle good uses of genetic science and healthcare – even if there is cause for caution with respect to experimentation, privacy, equity of access, 'germ line therapy' and 'genetic enhancement'. The big problem is: now and for the foreseeable future the principal use of this technology will not be therapeutic at all. It will be used for testing unborn children. And where the child is diagnosed as carrying some major disease, the mother is likely to choose or indeed to be steered – 'non-directively' of course – by doctors, counsellors, family and friends towards a genetic termination of pregnancy. My friends Tom and Clare suffered acutely from these pressures from various 'enlightened' and 'well-meaning' people.

In a moving article about his daughter Domenica who has Downs Syndrome, Nigel Lawson wrote about the complicity of genetic technology in the current search and destroy against Down's babies. Cystic fibrosis, spina bifida, Downs, predisposition to heart attack: where will it stop? The US National Academy of Sciences has reported that already people are losing their jobs and health and life insurance because they or their spouse or their child or their yet-unborn or yet-unconceived children have a genetic predisposition to some adverse condition. Personal preference and social pressures on parents to produce the perfect child and abort any imperfect ones are already there, and they are likely to grow. A couple who choose not to have a test for, or not to abort a child with, say, Downs Syndrome, may well be regarded as backward, superstitious, selfish, socially irresponsible, even criminal. What, we might wonder, will become of those who escape the genetic screening net and are born with genetic defects in such a world: far from being welcomed and given every opportunity by a sympathetic human family, these children may come to be regarded and treated as parasites, a drain on limited resources and sympathy.

Who decides which genetic qualities warrant death, before or after birth? On what basis? And in whose interests? Eugenics, far from being a Nazi German or Chinese monopoly, affects the thinking of many 'enlightened' and apparently good willed people, and is told in the high and growing rate of genetic search and destroy missions (called 'prenatal screening and genetic termination'). Behind this, the Pope suggests, lies "an exclusivist mentality that would deny solidarity with those who are different to ourselves or who call forth from us some degree of self-sacrifice". The view that the handicapped are better off never born, never existing, is certainly very much at odds with the Gospel which values every human being as a sister or brother, relativizes all handicap, and emphasizes the power of the weak to minister to the strong; it is also contrary to the principle of justice, shared by many people of all religions and none, of equal respect for the dignity and life of every human being, especially the vulnerable and powerless.[25]

Until recently the targets of genetic search and destroy have been those with severe handicaps who could easily be identified *in utero*. But the list of those handicaps is growing, partly as a result of increased technical capacity to

identify more and more of them, more and more accurately; and partly as a result of the line moving as to which handicaps are regarded as incompatible with worthwhile existence.

I was once consulted regarding a case of a dwarf couple who presented at a hospital pregnant and requesting genetic screening. On being told their child was perfectly normal they declared that they wanted an abortion. The clinical staff were aghast: despite long experience of abortion on demand, they had never before faced a case where a child was to be aborted specifically because she or he was normal! The case raised for them all sorts of questions about the nature of health and handicap, and whether individual parents, medicos or societies are entitled to decide which conditions warrant the death of a child, whether in the child's best interests or the interests of others.[26]

The cover-feature of the April 1998 number of *Life* magazine confidently included the following qualities among those entirely or largely genetically determined: eye, hair and skin colour; sex; body shape and athletic prowess; intelligence of various kinds; insomnia, blood pressure, migraines, depression and psychosis; shyness and aggressiveness, risk aversion and thrill-seeking, optimism, extroversion and alienation, leadership and career choice; æsthetic sensibility, sexual orientation, tastes and addictions; and, I was interested to learn, religiosity.[27] Nor are such claims the preserve of pop magazines: David Roshland, the one-time editor of the prestigious journal *Science,* even attributed homelessness and unemployment to genetic defects!

If genetic factors are indeed identified as contributing to many of these qualities, children who do not measure up to parental and social expectations may be targeted for destruction. I am far from confident that talk of multi-factorial causation, the importance of environment, the ambiguity of test results, and so on, will do much to stop that. One recent study found that three-quarters of young Americans polled would choose abortion if told their fœtus had a 50% chance of growing up obese.[28] Fat baby tests may well be on the market within the decade. The target group for genetic screening and destruction is growing all the time...

There are lots of things which can and should be said about the genetic revolution which is ahead of us: the dangers of the all-too-common reduction of people to their genes; the pressure which the very availability of these tests puts upon parents and health professionals to use them and then to join the genetic abortion treadmill for all the talk of reproductive liberty; the power of the technological imperative to sweep people along in its path and become an overarching ideology for medicine; the informative natural revulsion of ordinary people towards some extremes of contemporary genetic science. But my main point here is that here we have a technological revolution already under way which, for all its much vaunted therapeutic potential, will in the foreseeable future contribute more to death in the womb than to therapy and health there.

Meanwhile a whole new generation of 'morning after pills', 'emergency contraceptives' and abortifacient drugs is being and will be developed, further blurring the line between contraception and abortion. And embryos galore are being created in laboratories and will probably be created in increasing numbers by cloning and other techniques in the future, then experimented upon or exploited for body parts or disposed of, without any serious outcry from populations systematically desensitized to the evil of killing early human life.[29]

The result: we now have abortion on an unthinkable scale, more devastating in sheer number of fatalities than the great world wars, the great plagues and famines, the great natural disasters – killing millions and millions of children every year till we are so used to it we are all desensitised to the daily death-toll. And wherever abortion is so commonly and publicly practised, it tends to be trivialised. Last year two Americans were convicted for killing on the same day: one, a Milwaukee man who had shot his cat to death because it hissed at him, was sentenced to 21 years in prison; the other, a New Yorker who had illegally performed abortions on two babies already mature enough to survive perfectly well outside the womb, was given no prison sentence at all, only a five year period of probation. In many Western countries a third or more of women now have an abortion in their lifetime; in countries such as Russia most women by far do so. This makes abortion the most common surgical procedure in the world, and ensures that the emotional, ideological and financial investment of many in the justification and continuation of this particular variety of homicide is very great – even as more and more women are terribly damaged by it. The outgoing US President supports even 'partial-birth' abortions, a practice so grotesque it has shaken the collective conscience of even the AMA. Where America will go on this issue in the months and years ahead will I think be crucially symbolic of where our civilisation at its present crossroads is going to turn.

As a result of all this Christian and other pro-life doctors, nurses and pharmacists can expect to be pressured to compromise their position or be increasingly marginalized. They will stand on *the frontier between life and death in the womb* and it may be a fairly lonely place. For the Church this presents an enormous evangelical and pastoral challenge: how are we better to support pro-life health professionals living on this frontier? How are we better to preach our Gospel of Life, better to convert and reconcile those who have acted contra-life, and better to support those who might be tempted to act against life in the womb or the laboratory? How do we make a world in which the little Thomas Walters will be 'welcome at the inn', rather than the victims of 'early induction', and where distressed mothers-to-be are supported through their pregnancy and beyond, rather than press-ganged into abortion by a cop-out society?[30]

3.2 On the frontier between "respect for the dignity of the person" and "the commodification of persons"

Wherever people aspire to small or no families, wherever 'sex education' means in practice acquiescing in unchaste sexual activities and seeking only 'harm minimisation' strategies, wherever individualism and moral subjectivism are rampant, both sexual activity and contraceptive rates go up, and so too, inevitably, do pregnancy and abortion rates. Perhaps the area where twentieth century medicine wrought the most extraordinary changes was not in surgery or even vaccinations, but in 'family planning':

through the provision of devices, drugs and surgical procedures, biotechnology has promised sexual activity on demand supposedly without the 'threat' of unwanted pregnancy and children.[31]

The search for the perfect contraceptive and abortion will continue into the future, and the personal, social and cultural ramifications continue to be colossal, but I will not dwell on them here. Apart from stopping babies, medicine has also advanced in enabling them: artificial reproductive technologies have produced hundreds of thousands of live-born children and destroyed millions of unborn, embryonic children in the process.[32] People can now commission others to provide those requisites of child-bearing which they cannot or do not provide themselves. Eggs, sperm, embryos, womb, technological wherewithal, all may come from people other than those who actually want the child. Those involved may or may not be related to the child or to each other; they may be married, unmarried, homosexual or solo; they may be paid or unpaid, alive or dead, comatose or even aborted and never born. Cryopreservation allows twins to be born at different times and to different parents, even many years after their genetic parents' deaths, and even to be born into different generations. Through genetic manipulation, parthenogenesis, cloning and induced chimeras, people in the future may have only one or many genetic parents, and possibly many twins, and these children might be designed so as to have certain preferred human or non-human characteristics, or to be cannibalised for genomic material for sick adults or for body parts for their families. Depending upon market demand, post-menopausal women, surrogate mothers, men, animals and machines can carry children; children can be created in memory of deceased lovers; and much else which we have not yet even imagined will soon be achieved.

What about the children? In an age when the right of adults to have whatever they want – houses, cars, videos, whatever – on demand, in whatever colour and model they desire, to use at will and discard when unwanted, is being extended to everything, are children becoming the ultimate commodity, the last consumer good for the person who has everything? Will they increasingly be manufactured to satisfy the preferences of the me-generation, and disposed of when they fail to do so by the throw-away society?

In my own country a Federal Court recently ruled that single women and lesbians have a right to state funded artificial insemination and in vitro fertilisation, that it is discriminatory to restrict such services to married or even de facto married heterosexual couples. The thought seemed to be that the wherewithal for child-making, and by implication children themselves, are good and services to which all should have access whatever their circumstances. No one spoke for the children in this case except the Catholic Church – the silence on that score from government, courts and civil rights agencies was deafening. In an age where the consumer society and the autonomy obsession have invaded the cradle and even the genome, the tendency is increasingly to regard parenting not as a trust received so much as a project chosen, not as receiving a gift so much as going shopping.

Leon Kass describes the difference this way: when a couple chooses to procreate, they come together to give or to risk giving existence to another being who is formed, exactly as they were, by what they are: living, bodily, mortal, imperfect, passionate beings. They say yes to the emergence of a new life in all its novelty, however that child turns out. Embracing the future by procreating means relinquishing some of our grip. For our children are not our children, they are not our possessions, not our projects. They are sprung from the past, but they take an uncharted course into the future. In genetically controlled conceptions, on the other hand, "we give existence to a being not by what we are but by what we intend and design. As with any product of our making, no matter how excellent, the artificer stands above it, not as an equal but as a superior, transcending it by his will and creative prowess."[33]

The new genetics is morally problematical, therefore, not only because it stands on the frontier between life and death in the womb, but also because it tends to commodify even those children

whose lives are not threatened by it. It can so easily represent yet another grave imposition by parents of their preferences upon children and a further rejection of the traditional notion that "children should be accepted by their parents as a divine gift to be loved for what they uniquely are and not merely because they conform to the parents' hopes and expectations".[34] Procreation becomes mere reproduction, replacing being *begotten* with being *made*, making children into quality-controllable commodities, and pregnant mothers into test drivers. And genetic screening has the power to detach us (both figuratively and literally) from our children, making every pregnancy 'tentative' and requiring of mothers a certain distance until all is judged well and good.

Of course biotechnology is not just about life and death dealing measures. As I was writing this paper I was struck with renal colic. It is a terrible affliction and there is no comfort in being told that childbirth is just as bad! Yet the experience highlighted for me the wonders of modern pain relief, diagnostic x-rays, keyhole surgery, laser treatment and lithotripsy. Biotechnological advances have allowed more people to live healthier lives and for longer, to be cured of various diseases and various unpleasant symptoms, and to have their suffering alleviated in various ways. And much of this is a very great benefit.[35] Yet it all comes with its own moral dilemmas, such as the appropriate distribution of health resources.[36]

Even more troubling are the uses of these technologies which seem to treat the body as if it were a mere thing rather than the concrete expression of a unique person.[37] The instrumentalisation of the corpse, and even of the body of the consenting live donor, is an aspect of organ harvesting which is yet to receive sufficient theological reflection.[38] Another example is the application of drugs, hormones and surgery not to correct defects but merely to eradicate the signs of perfectly normal ageing or to change body shape, colour or sex according to personal preference. Cindy Jackson, who runs London's thriving 'Cosmetic Surgery Network', made headlines by writing up her nine years, 37 operations and hundreds of thousands of pounds spent on having herself surgically remade as close as possible to the 'Barbie' doll. Surgeons turned Cindy's lips inside out and padded them with fat from her bottom. They widened her eyes, broke and reset her jaw-bone, sawed her chin down to size and implanted her cheeks with silicon. They dermabrased her face, did two nose jobs on her, as well as cosmetic dentistry and a hair transplant. They liposuctioned her hips and thighs, and enlarged her breasts. She has had three facelifts and annual ones are projected hereafter. Many women have since hired Cindy's surgeon to follow the same blueprints and make them into Cindy 'clones'. Much more in the way of body engineering will be possible in the future.

The big field for the future in mid-life biotechnology will, however, be in controlling human ca-

pacities such as strength, agility, reflexes, emotions, memory, imagination, desire, libido, aggression, thought, choice, speech and action.[39] These techniques are in a rather primitive state at the moment, but already we have a battery of surgical techniques such as sex-changes and elaborate cosmetic and other reconstructive surgery, and drug techniques, especially use of tranquillisers and stimulants, uppers and downers, 'consciousness-expanding', euphoriant and hallucinogenic pharmacology. The future promises of memory-enhancing pills, mood controlling pills, pleasure-inducing pills and like. Hyperactive and troublesome children, old people in nursing homes, and emotional people in mid-life are increasingly tranquillized; anabolic steroids and various other performance-enhancing drugs marred the recent Olympics in my homeland; recreational drug-taking is commonplace and most of it terribly harmful; and the pharmaceutical industry, both licit and illicit, is constantly creating new products, new markets, and new dependencies. In all this children, adolescents and adults, like unborn children before them, risk being treated not as subjects of care so much as objects of manipulation, whether or not with their supposed consent. Rather than the proper loci of reverence, love and care, they become loci of hedonic preference fulfilment, consumer satisfactions, or technical manoeuvres.

As a result of all this Christian health professionals can again expect to be pressured and marginalized – as well as admired and praised – as they stand on a new frontier: *the frontier between respect for the dignity of the person and the commodification of persons.* Once more it could become a fairly lonely place. And once more it presents the Church with a great pastoral and evangelical challenge: how are we better to support health professionals living on this frontier? How are we better to preach the dignity of every human person, and better to convert and reconcile those who treat human beings as mere commodities?

3.3 On the frontier between "natural death" and "medicide"[40]

The notion that death can be 'tamed' is a potent one in ancient mythology and in modern science. Developments such as organ transplantation, xenotransplantation, artificial organs, genetic engineering and other research into slowing or stopping

ageing – all very promising in themselves – hold forth the promise of increasing not just the average age, so that most people achieve an ordinary life-span, but also the maximum life expectancy. According to some estimates it may soon be possible to add twenty to forty years to the human life-span: the death in August 1998 of the 122-year-old Frenchwoman, Jeanne Calment, may one day be unremarkable. The World Health Organisation predicts that the number of centenarians in France will rise from the 200 there were in 1950 to around 150,000 by 2050.[41] This raises all sorts of questions about when to apply and when to withhold life-sustaining treatments, how long to extend life or perhaps prolong dying, including of course the added burden on our aged care system. But my main point here is that, as with the efforts at cosmetic surgery to remove all signs of ageing, there is a doubly vain notion that eternal life and youth can be had here on earth. The fact is that even baby faced young priests get kidney stones: we are all going to die and death, our last enemy, cannot be tamed.

The other way to 'tame' death, of course, is to make it part of the medical armoury. In one part of my own country voluntary euthanasia was briefly legal in the 1990s and the campaign in many parts of the world for the regularisation of that practice continues. Christian care for the elderly and the dying is under considerable pressure at present and is likely to be under even more pressure in the future.[42] Even from the cross Christ showed his care for a dying thief; and as Christ himself died his own mother and beloved disciple stood by him. The task of Christian healthcare is to care even when it cannot cure. Christians have been at the forefront of the hospice movement, in specialized care for the dying, including but not limited to the increasingly effective science of palliative care. But the task of caring well for the terminally ill is especially challenging in a world increasingly inclined to discrimination, abandonment, even medicide – medical homicide – towards the terminally ill, all dressed up as respect for rights, mercy for those who cannot be cured, and efficient use of resources. And it is all the more difficult to hold the line when even theologians and health professionals of good will disagree about such fundamental issues as whether we should feed and hydrate unconscious patients.[43]

I need not spell out here why this matters so much to us. Suffice it to say that essential to respect for the precept against killing and to the killing-letting die distinction of classical and Christian medical ethics is a high view of human dignity and equality, and of our moral responsibilities in acting and forbearing to act with respect to it. This brings the Christian health professional into direct conflict with the values of a culture which says happiness is about contentment and control; that says people matter for how much they produce or consume or contribute in some other way; that says choice is king and each may choose how he lives *and dies*. Standing on *the frontier between natural death and medicide,* Christian health professionals may in yet another respect find themselves pressured and deserted. Once again this challenges us pastorally and evangelically: how are we better to preach the dignity of elderly, frail and dying people, and better to convert and reconcile those who think comfort and self-determination must trump all else and that medical killing can thus be justified? How are to support those life-affirming health professionals living on this frontier – in their understanding, their conviction, their resolve, their perseverance in morally sensitive care despite hostility from some quarters?

4. Conclusion

I began my lecture this evening with the story of Clare and Tom and their little baby Thomas doomed to death so soon after birth. That story I think very poignantly brings home the several frontiers on which health professionals and their patients find themselves today. If we look in one direction we see healthcare as a merely technical achievement or market product, provided by mere technicians, 'service–providers' or 'hired guns', and limited only by the technically and politically possible: this is, of course, healthcare in 'the culture of death' and it is ultimately amount neither health nor care. If we look the other way on our frontier, however, we see healthcare as a vocation, engaged in by people who are professionals and saints-in-the-making, and whose activities with their own proper goals and are subject to common morality: this is genuine healthcare, part of the building up of 'the civilisation of life and love'. Tom and Clare and their little baby and their carers stood on that frontier. Likewise they stood on the three new frontiers between life and death in the womb, between respect for the dignity of the person and the commodification of persons, between natural death and medicide. They had some hard choices to make. And their story is paralleled thousands of times a day around the world in Christian healthcare institutions and in the work of Christian health professionals. Thomas Walter Ryan was born on 18 December 1996 and died soon after. But his story, and the story of his family, goes on. In the same hospital, exactly one year later, on the very same day but in 1997, with some of the very same carers in attendance, his brother Isaac Peter Ryan was born. Isaac is alive and well...

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Notes

[1] The Ryan family's story is told more fully in: "Thomas Walter Joseph Ryan: celebration of a life," *Bioethics Outlook* 8(2) (June 1997), 1-3.

[2] On the vocation of healthcare see Pontifical Council for Pastoral Assistance to Healthcare Workers, *Charter for Healthcare*

Workers (1995), 1-10. I explore some of these issues at greater length in: "Is there a distinctive rôle for the Catholic hospital in a pluralist society?" in Luke Gormally (ed), *Issues for a Catholic Bioethic* (London: Linacre Centre, 1999), 200-230.

[3] Mt 15:30-31.

[4] National Conference of Catholic Bishops (USA), Ethical and Religious Directives for Catholic Healthcare Services (1994).

[5] *Cf.* JOHN PAUL II, *Salvifici doloris: Apostolic Letter on the Christian Meaning of Human Suffering* (1984).

New Jersey Bishops, "The rationale of Catholic healthcare," *Origins* 25(27) (Dec 21 1995), 449-452, at 451: "We are a community of faith and worship and fraternal love and care, who know who we are and become who we are through the life, death and resurrection of Jesus... [In him we recognize] the God who suffered along with us... In his resurrection we acknowledge not only the power of God, but also the new life given by God... God dwells with us and within us through the power of the Holy Spirit and that makes us really and truly different... We who have been touched and saved and changed by God must make all this visible not only by our grateful faith-filled praise of God, but also by our loving presence with each other and our compassionate care for one another. Catholic healthcare exists as a practical sign of living faith; it exists 'to be Jesus' love for the other in the healthcare setting'."

US Bishops 1994: "For the Christian, our encounter with suffering and death can take on a positive and distinctive meaning through the redemptive power of Jesus' suffering and death. As St. Paul says, we are "always carrying about in the body the dying of Jesus, so that the life of Jesus may also be manifested in our body" (2 Cor. 4: 10). This truth does not lessen the pain and fear, but gives confidence and grace for bearing suffering rather than being overwhelmed by it. Catholic healthcare ministry bears witness to the truth that, for those who are in Christ, suffering and death are the birth pangs of the new creation. "God himself will always be with them. He will wipe every tear from their eyes and there shall be no more death or mourning, wailing or pain, for the old order has passed away" (Rev. 21: 3-4).

Cf. Juliana Casey, *Food for the Journey: Theological Foundations of the Catholic Healthcare Ministry* (St Louis: Catholic Health Association, 1991); Alasdair MacIntyre, "Can medicine dispense with a theological perspective on human nature?" In D. Callahan and H. T. Engelhardt (eds), *The Roots of Ethics* (New York: Plenum, 1981), 119-138.

[6] *Summa theologiæ* IIa IIæ 25, I; 103-109; IIIia 25,ii.

[7] US Bishops (1997). Administrative Committee of the National Conference of Catholic Bishops (USA), *The Bishops' Pastoral Rôle in Catholic Healthcare Ministry* (1997) in *Origins* 26(43) (Apr 17), 700-704 at 704.

In *Vita Consecrata: Apostolic Exhortation on the Consecrated Life and its Mission in the Church and in the World* (1996: §83), John Paul II describes the *diakonia* of nursing religious in terms which might be applied more generally to all those who share in the Catholic healthcare apostolate: "The Church looks with admiration and gratitude upon... [those] who, by caring for the sick and the suffering, contribute in a significant way to her mission. They carry on the ministry of mercy of Christ, who 'went about doing good and healing all [who were oppressed by the devil]' (Acts 10.38). In the footsteps of the Divine Samaritan, physician of souls and bodies, and following the example of their respective foundresses... [they] should persevere in their witness of love towards the sick, devoting themselves to them with profound understanding and compassion. They should give a special place in their ministry to the poorest and most abandoned of the sick, such as the elderly, and those who are handicapped, marginalized, or terminally ill, and to the victims of drug abuse and the new contagious diseases."

[8] Wisdom 11: 26. See *Charter* §3; and BONIFACIO HONINGS, "The *Charter for Healthcare Workers*: A synthesis of Hippocratic ethics and Christian morality," *Dolentium hominum* 31 (1996): 48-52.

[9] The literature on the 'Catholic identity' of healthcare institutions is now considerable. See, for instance: JOHN R AMOS *et al*, *The Search for Identity: Canonical Sponsorship of Catholic Healthcare* (St Louis: Catholic Health Association, 1993); BENEDICT ASHLEY OP, "The documents of Catholic identity," in R. E. SMITH (ed), *The Gospel of Life and the Vision of Health Care: Proceedings of the 15th Workshop for Bishops* (Braintree: Pope John Center, 1996), 10-16; JOHN BEAL, "Catholic hospitals: how Catholic will they be?" *Concilium 1994-5: Catholic Identity* (London: SCM, 1995) 81-90; JOSEPH BERNARDIN, "Crossroads for the Church's health care ministry," *Origins* 22(24) (Nov 26 1992), 409-411; Catholic Health Association (USA), "How to approach Catholic identity in changing times," *Health Progress* (Apr 1994), 23-29; JOHN E CURLEY, "Catholic identity, Catholic integrity. *Health Progress* (Oct 1991), 56-69; RICHARD MCCORMICK, "The Catholic hospital: mission impossible?" *Origins* 24(39) (Mar 16 1995), 648-653; THOMAS MURPHY, "What is the bottom line in Catholic healthcare?" *Origins* 26(4) (Jun 13 1996), 56-60; JOHN O'CONNOR, "The temptation to become just another industry: healthcare," *Origins* 25(27) (Dec 21 1995), 452-454;

[10] The anathemas against witch-doctors in the Old Testament (Lev 20:27; Dt 18:10-14; 1 Chr 10:13-14; *cf.* Acts 13:6-12) and against the pharmacists (farmakoiV) in the New (Rev 21:8; 22:15) draw our attention to the dangers of 'medicine' become 'magic'. *cf.* STANLEY HAUERWAS, "Salvation and health: why medicine needs the Church," in EARL SHELP (ed), *Theology and Bioethics: Exploring the Foundations and Frontiers* (Dordrecht: Reidel, 1985), 205-224; and GILBERT MEILAENDER, *Body, Soul, and Bioethics* (Notre Dame: University of Notre Dame Press, 1995).

[11] Lk 5:17-26; *cf.* Mk 2:1-12.

[12] US Bishops 1994; *cf. Charter* §3.

[13] *Charter* §§ 108-113. *cf.* US Bishops 1994 direct that "for Catholic patients or residents, provision for the sacraments is an especially important part of Catholic healthcare ministry. Every effort should be made to have priests assigned to hospitals and healthcare institutions to celebrate the Eucharist and provide the sacraments to patients and staff... Particular care should be taken to provide and to publicize opportunities for patients or residents to receive the sacrament of penance... Responsive to a patient's desires and condition, all involved in pastoral care should facilitate the availability of priests to provide the sacrament of anointing of the sick, recognizing that through this sacrament Christ provides grace and support to those who are seriously ill or weakened by advanced age.... All Catholics who are capable of receiving communion should receive viaticum when they are in danger of death, while still in full possession of their faculties.... Newly born infants in danger of death, including those miscarried, should be baptized if this is possible... When a Catholic who has been baptized but not yet confirmed is in danger of death, any priest may confirm the person. (Directives 12-18). Likewise *Charter* §§108-113.

[14] US Bishops 1994.

[15] *Cf.* Honings 1996. STANLEY HAUERWAS, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped and the Church* (Notre Dame IN: University of Notre Dame Press, 1986), 81 observed: "No matter how powerful [medicine] becomes, it cannot in principle rule out the necessity of prayer. For prayer is not a supplement to the insufficiency of our medical knowledge and practice; nor is it some divine insurance policy that our medical skill will work; rather, our prayer is the means that we have to make God present whether our medical skill is successful or not. So understood, the issue is not whether medical care and prayer are antithetical, but how medical care can ever be sustained without continued prayer."

[16] *Cf.* AUGUSTINE DI NOIA OP, The virtues of the Good Samaritan: healthcare ethics in the perspective of a renewed moral theology," *Dolentium hominum* 31 (1996), 211-214; ALASDAIR MACINTYRE, *Dependent Rational Animals: Why Human Beings Need the Virtues* (London: Duckworth, 1999) (and his many previous works); GILBERT MEILAENDER, "Are there virtues inherent in a profession?" in EDMUND PELLEGRINO *et al* (eds), *Ethics, Trust and Professions* (Washington DC: Georgetown UP, 1991), 139-55; EDMUND PELLEGRINO, "Toward a virtue-based normative ethics for the health professions," *Kennnedy Institute of Ethics Journal* 5 (1995): 253-277 (and his many other works on virtue).

[17] Lk 4:18.

[18] Mt 4:23; 9:35.

[19] Mt 10:7-8.

[20] JOHN PAUL II, "Address to healthworkers at the Mercy Maternity Hospital, Melbourne, 28 November, 1986," *Insegnameni* IX/2 (1986), 1734.

[21] *Cf.* DIEGO GUILLEN, "The Hippocratic Oath in the development of medicine," *Dolentium hominum* 31 (1996): 22-28.

[22] *Cf.* JOHN PAUL II, *Evangelium Vitæ: Encyclical on the Value and Inviolability of Human Life* (1995) and innumerable speeches on healthcare issues. Amongst the contributions from the Congregation for the Doctrine of the Faith are *Quæstio de abortu: Declaration on Procured Abortion* (1974), *Haec sacra congregatio:* Declaration on Sterilization in Catholic Hospitals (1975), *Declaration on Certain Questions concerning Sexual Ethics* (1976), *Jura et Bona:* Declaration on Euthanasia (1980), *Donum vitæ:* Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation (1986) and, most recently, the interventions with respect to abortion counselling and injecting rooms in Germany and Australia respectively. Some of these and other magisterial documents are collected in: KEVIN O'ROURKE AND PHILIP BOYLE (eds), *Medical Ethics: Sources of Catholic Teachings* (2nd ed,. Washington DC: Georgetown University Press, 1993).

[23] *Cf.* BRUNO ZANOBIO, "The ethical dimension of Hippocratic medicine and its specific relationship to Christian morality," *Dolentium hominum* 31 (1996): 29-32.

[24] I give a fuller account of some of these matters in: "Adult science and adolescent ethics: A response to John Henley," in HILARY REGAN *et al* (eds), *Beyond Mere Health: Theology and Health Care in a Secular Society* (Melbourne: Australian Theo-

logical Forum, 1996), 145-168; "The brave new world of genetic screening: ethical issues," in JOHN FLADER (ed), *Death or Disability? Proceedings of a Seminar at the University of Tasmania* (Hobart: University of Tasmania, 1996), 16-34; and "The human genome project: hopes and fears," *Philippiniana Sacra* 30(90) (Sept-Dec 1995), 483-498.

See also: *Charter* §§ 12-14.

[25] See Hauerwas 1986 and MacIntyre 1999, ch. 1.

[26] For fuller details of this case see: ANTHONY FISHER OP, "Ethical issues in genetic screening," *Bioethics Outlook* 8(4) (Dec 1997), 1-12.

[27] GEORGE COLT, "Were you born that way?" *Life* (April 1998): 38-50.

[28] Colt 1998.

[29] On these matters see: *Charter* §§ 35-36, 42-46, 139-146.

[30] For heart-rending accounts of this terrible process and its after-effects, see Melinda Tankard Reist's excellent book, *Giving Sorrow Words: Women's Stories of Grief After Abortion* (Sydney: Duffy & Snellgrive, 2000).

[31] On these matters see also *Charter* §§ 15-20.

[32] I give a fuller account of some of these matters in: "The brave new world of reproductive technologies," *Philippiniana Sacra* 30(89) (May-Aug 1995), 277-292. See also: *Charter* §§ 21-34.

[33] *Cf.* LEON KASS, "The wisdom of repugnance: why we should ban the cloning of humans," *The New Republic* 216(22) (2 June 1997), 17-26 at 20-24.

[34] BENEDICT ASHLEY OP AND KEVIN O'ROURKE, *Healthcare Ethics: A Theological Perspective* (4th ed, Washington DC: Georgetown UP), 317; *cf.* CDF 1986.

[35] See also: *Charter* §§ 56-58, 62-71.

[36] I give a fuller account of some of the dilemmas in this area in: "Accountant, Pollster, Samaritan: three models of justice in health care resource allocation," in JOHN FLADER (ed), *Health Care in the Balance: Ethical Issues in Medical Funding* (Hobart: University of Tasmania, 1997), 13-26; and the forthcoming *The Allocation of Healthcare: An Ethical Framework for Policy* (with Luke Gormally and others, London: Linacre Centre, for the British Bishops).

[37] See *Charter* §§ 38-41.

[38] See some of my questions in "Contrasting ethical approaches to organ transplantation and xenotransplantation," in FAUSTO GOMEZ OP AND ANNIELA YU-SOLIVEN (eds), *Love and Life-Making, Confidentiality, Xenotransplants and Aging* (Manila: UST Department of Bioethics, 2000), 75-110.

[39] On these matters see: LEON KASS, *Toward a More Natural Science: Biology and Human Affairs* (New York: Free Press, 1985); *Charter* §§ 92-107.

[40] See *Charter* §§ 114-124, 130-138, 147-150. I give a fuller exposition of some of these ideas in: "Theological aspects of euthanasia," in JOHN KEOWN (ed.), *Examining Euthanasia: Legal, Ethical and Clinical Perspectives.* Cambridge: Cambridge University Press, 1995, pp. 315-332; and "Why the Lords rejected euthanasia," *Human Life Review,* 22(3) (Summer 1996), 15-23.

[41] World Health Organisation *Annual Health Report,* 11.05.97.

[42] *Cf.* O'Connor 1995.

[43] I give fuller accounts of this dilemma in "On not starving the unconscious," *New Blackfriars,* 74 (Mar 1993), 130-145; and "Should we starve the unconscious?" *Australasian Catholic Record,* 74(3) (July 1997), 315-329.

TOMÁS BARRIENTOS FORTES

IV: The Teaching of the Future Professionals of the World of Health and Health Care

The training of medical professionals has always been one of the first activities of universities. This has been the case ever since their creation. Together with theology and the humanistic sciences, medical instruction occupied an important place in the activity of universities.

During the nineteenth century, at the time of the industrial revolution and social modernisation, medical instruction began to undergo a transformation. It began to involve scientific methodology in a formal way in the way it was imparted. With the advent of anaesthetics and the modern theories of asepsis and antisepsis the techniques of surgery began to be included in the therapeutic battle. This lay behind the fact that medicine had to be taught not only in a theoretical and individual way through a tutor, as until that moment had usually happened, but at the same time required the student to be in contact with the basic medical sciences, which had been enriched by the discoveries of the epoch in physiology, biochemistry, histology, and the study of infectious diseases.

At the beginning of the twentieth century Flexner, in North America, with the financial support provided by the Carnegie Foundation, carried out a detailed study of the realities of medical instruction as they obtained at the beginning of the first decade of the century. Flexner was surprised by the great variety of teaching programmes which, given their very heterogeneous range of con-

cerns, encountered notable difficulty in the provision of a medical instruction which could be homogeneous in a qualitative sense. At that time the idea of the establishment of universal standards of quality in medicine was seen as a goal to be aimed for, and it was thought that it was necessary to prevent the medical schools from training medical doctors of different levels of quality. It was difficult to graduate them and subsequently achieve a safe and efficient practice of medicine.

The impact of Flexner in establishing the configurations of the programmes of medical instruction was of the very greatest importance. But during the epoch when he was alive half of the medical schools of the United States of America had to close because of the low standards of their teaching curriculums. Flexer laid stress on the involvement of disciplines of basic science at the beginning of the career of the medical doctor. Subsequently, it was necessary to include the teaching of the clinical sciences, and there had to be a constant emphasis on the physiopathology of the nosological pictures in the basic sciences. The inclusion of the clinical laboratory and basic imaging of the human body, represented to begin with by simple radiography, were the pillars on which Flexner decided to base the reorganisation of the systems of teaching of the medical schools of his time. Gradually, the influence of North American medicine spread throughout the world. This expansion was supported by the events which followed the Second World War, when the world economy was built up again under the strong influence of North America. During the growth and development of medicine during the

second part of the twentieth century, the advance of medical technology in both the fields of diagnosis and that of treatment and therapy was very impressive. Forms of microtechnology, pushed forward by scientific advance and progress (the fruit of the space era and the beginning of the electronic and computer era), were the principal engines behind this change.

The ability to explore the inside of the human body at a molecular level revolutionised both our knowledge of the body itself in terms of its architecture and its functions and our knowledge of the physiopathological reactions of the human body to damaging stimuli, whether of an external or an internal origin.

With the discoveries of the biochemistry of genetic mechanisms the path was opened up to the complete ability to analyse the development of the cells, the tissues, and the organs of the human body. The perfect way in which our Creator had codified us in order to develop our bodies and our life functions in a process of adaptation to this world thus begun to be understood.

The decisive role of the images produced by electronic microscopes, together with the opportunities offered by molecular marking through the use of histochemistry, and the techniques of radioimmunoanalysis, allowed us to locate in a physical sense the specific sites where the fundamental reactions of cellular biology take place in the various cells of the human body and its organelles, and in the micro-organisms with which we come into contact.

The techniques of ultrafiltration and spectrophotometric analysis led contemporary biology to acquire a striking and impressive diversity. The quantity of expression molecules in the different cells of the corporeal economy is very great, and the most beautiful aspect of this is that every particular molecule is responsible for an original and specific biochemical action which determines the progression of a normal physiological sequence.

At the present time, in the majority of cases of pathology the concept of physical illness has to be explained at the level of the molecular sphere, given that treatment will also be directed toward correcting this cellular alteration through the application of forms of medicine of a very specific kind and type of activity to the cellulars or the receptor sites within the human organism. This same specific character of the approach has meant that present-day medicines are more effective, powerful and safe because their secondary effects are reduced to a minimum by the very specific character of their action.

However, medical technology has grown and developed under a

terrible economic stimulus. The cost of the development of both diagnostic and therapeutic forms of technology has reached record levels and has made them excessively expensive for the population in general.

The population of the world has also undergone a major growth. According to data furnished by the United Nations, over six milliard human beings populate the planet. However, despite the fact that we already have the technological resources which allow us to achieve an effective identification of, and to engage in preventive action in relation to, nearly all illnesses, we cannot utilise them to the benefit of the world's population considered as a whole.

What has just been observed has its roots in part in the bad distribution of the global economic income, and in part in the socio-cultural realities of the various regions of our planet. At the present time, despite the fact that we have very sophisticated drugs and medicines and very advanced instruments for the creation of diagnostic and therapeutic images, over half of the medical consultations which take place in North America involve alternative medicine. Hydrology, magnetic medicine, naturism, acupuncture, homeopathy, herbalism, and other non-scientific medical practices, instead of diminishing in importance seem to be engaged in a self-confident ascent. In large part this is due to the lack of regulation by health care governmental authorities which is present in all the countries of the world. We should not forget that most people in government are not medical doctors and do not know about the importance of these non-scientific branches of alternative medicine. On the other hand, because they are 'not very remunerative' and 'involve little risk', such practices have not gained the attention of people in government with a view to regulating them as has hitherto been the case with scientific medicine, which belongs to the sphere of concern with looking after the world's health. Equally, we should not deny that those who practise alternative medicine often place greater emphasis on the human relationship than on the instruments and techniques they employ to provide treatment. There can be no doubt that in the field of health and health care humanism continues to prevail in the use of curative methods and techniques, whether of a scientific or an alternative character.

In the light of what has just been outlined, it is indispensable to redirect medical instruction in the rational use of, and the correct cost/benefit approach to, the medical-diagnostic and therapeutic resources which are now available to medical science.

This instruction should not be confined exclusively to the training of new medical doctors. It should also involve on-going medical instruction for medical doctors who have already graduated and are engaged in the daily practice of clinical medicine.

It is difficult to imagine what should today be the profile of medical doctors. However, for the medical profession to survive in modern times the primary goal of medicine should not be lost from sight – that of taking care of the health of mankind and seeing the human being as an *end* and not as a *means*. In this way humanism will always be the basis of the medical structure and will ensure that the individual is never relegated to second place. In this way it will act as a guide in relation to the daily ethics of medical practice. This is a reality which must be shared day after day by each and every medical doctor who is a part of that world community which is made up of those who serve health.

However, the environment which surrounds us has changed a great deal. These changes are to be found in an increased population, an improved management of information, better technology and a higher quality of life. Unfortunately, this reality is the prerogative of only a narrow number of people and has not reached a majority of the world population. Social injustice in economic distribution continues to be the element which hinders mankind in the promotion of the most advanced and up-to-date forms of progress in the knowledge and practice of medicine.

This injustice in the distribution of the world's resources is accentuated when one examines the particularities of each of the countries which make up the world concert of nations. For this reason, we must always recognise the advances in medical knowledge and health care resources at a world level, without confusing them and mixing them up with their availability at a local level, with particularities which belong to, and are characteristic of, each country of our planet. We should not despise the cultural and social values of each community of the world but try to incorporate the benefits of medical progress without dehumanising the individual, his family, or society as a whole. The globalisation of medical instruction and practice must not involve contempt for this element which is so relevant for the development and growth of humanity. The diversity of climatic and socio-economic contexts will establish barriers to the worldwide application of medical principles of a particular character. We must not contaminate local medical instruction through a universalisation of those particular features which do not correspond to all the realities of the world. In Mexico we often use a term which exemplifies what I have just said, that is to say 'to tropicalise' (*tropicalizar*). This refers to the application of universal medical knowledge at the level of its processes rather than in terms of its fundamental universal bases. The history of humanity has demonstrated for over two thousand years that universal principles are constantly redefined and that an adherence to the dogmas of scientific or non-scientific medical practice often leads to their obsolescence over time.

One of the missions which we as a Church have in the field of health and health care is that of favouring and promoting access to better forms of health service for all the populations of the world. Our Lord left to us the apostolic mission of going out into the world to take care of the sick in their suffering and where possible to cure their illnesses, to

help them along the lines taught us by the Good Samaritan, to be moved by solidarity in our conduct and behaviour to convert this mandate into reality, to be committed to our brothers and sisters and to give them the best of what we have for their care and treatment. But at the same time we must see ourselves as one large family, we must see that we are all brothers and sisters in Christ, from whom we obtain the resources and the inspiration to defeat illness. We must also oppose illness and find in Christ and through Christ all those resources which are needed to deal with out human condition, preparing ourselves at the same time for eternal life.

Today, with the phenomenon of globalisation, we have broken the barriers of non-communication, and we are the living witnesses of worldwide human suffering. The Church must, therefore, act in line with these times that we are now living, both at a universal level, through the Pontifical Council for Health Pastoral Care, and through her bishops in their local dioceses and through the religious and secular organisations rooted in the principles of Christianity which are produced by civil society and which are committed apostolically to their brothers and sisters within the Church in the building up of health care initiatives and services of both a local and a universal character.

Catholic medical schools must not abandon the task of training medical doctors who know at a fundamental level the workings and the structure of the human being, created in the image and likeness of his Creator. They should also be committed to look for the best routes and paths by which their neighbour can maintain his or her health, and recover that health which has been lost.

One must begin with the teaching of the concept of health as defined by the World Health Organisation and which the Holy Father brought to completion when he added what in reality is its most important aspect, that is to say spiritual well-being. This should be done so that it is understood that health is the physical, social, mental and spiritual well-being of the individual, and, when we refer to community health, of his or her community as well.

In this way, to medical doctors as well it will be taught that the promotion of health is an undertaking which involves the participation of the whole of the community, at both a local and worldwide level. For this reason, such activity cannot be carried out by the individual alone. Hence the imperative that medical schools should promote communication with, and the active participation of, their students, to their benefit and that of their communities, teaching them to work in a team, both as collaborators and as leaders in relation to their own colleagues. This approach of leadership must be promoted beginning with a Catholic vision of service strongly based on the social doctrine of the Church. At the same time the medical doctor must be educated to use those instruments of communication which enable him or her to keep in contact with his or her own patients, his or her own community, and the rest of the medical profession in an effective and up-to-date way, taking advantage of the opportunities which God provides us with day after day to the benefit of our patients. At the same time, we should engage in the communication between different specialists of medical information through telepresence medical programmes. In this way we can shorten the distance between patients and their medical doctors and achieve a better distribution of abilities and make them available to distant and remote places. In communicating in this way with the world one can promote care amongst all the populations of the universe.

Only by creating teams of medical doctors who know about medical science and are active in their communities, and by developing programmes which promote individual, family and collective health in specific communities, will we be sure to go on implementing this great mandate which we received from our Lord Jesus Christ two thousand years ago. In this way, his kingdom of peace and justice will be advanced and built so that, through the corporeal and community health which we enjoy in this life, we can obtain eternal life with him in his glory and eternity.

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RUDESINDO DELGADO PÉREZ

V: The Training of Chaplains

Introduction

I would like to divide the analysis of the subject which has been entrusted to me into three sections: first of all I will make certain observations, then I will provide some reasons for upholding the need and urgent importance of the training of chaplains and I will describe the ends and the fundamental contents of such training, indicating some of its characteristics and pointing out some of its stages and instruments, and finally I will present certain policies designed to bring about the implementation of such training.

1. Observations

First of all, I would like to make certain observations in order to contextualise and locate this subject, discern its importance, and understand its failings.

1. I will focus on the training of chaplains, that is to say the training of presbyters to whom has been entrusted the pastoral care of the faithful in hospitals. I will not dwell upon the training of those who, without being priests, provide religious assistance as members of the pastoral service of the Church, although what I will say is in large part applicable to them as well. This training without doubt deserves priority attention because one is dealing here with an essential route by which to achieve the renewal of the pastoral services provided by the Church.

2. I have observed the chaplains of that part of the first world where Latin culture prevails, although I do not have tried and tested evidence on the training of chaplains of Anglo-Saxon culture or in the third world. This is an important limit which I hope will be a stimulus for future work and initiatives in this field of formation.

3. In this paper I have chosen to centre the discussion around actual practice, although such a discussion is clearly based upon theoretical reflection on, and illumination of, the question in hand.

4. The sources on which this paper is based are the documents of the Magisterium of the Church on the training of presbyters, the reflections and experiences in relation to the subject of the Church over recent years, and my experience as a chaplain and Director of the Department of Pastoral Care in Health of the Spanish Bishops' Conference.

2. The Evident Need for, and Urgent Importance of, the Training of Chaplains

In the Church, above all beginning with Vatican Council II, training has been a constant and repeated element present in all fields and sectors. There has been a clear awareness of the fact that training and constant up-dating are a need and requirement when it comes to all those who exercise a profession, have a position, or engage in work, in order to be effective and up-to-date. In the case of the priest, training is required of him and it is an expression of the faithfulness of his ministry, his love for Christ, and a duty of justice in relation to the People of God who have the right to service to the Word, the sacraments, and charity (*PVD*, 72).

With respect to chaplains, the need for their training is a reality for the further following reasons:

1. The chaplain carries out his mission in an institution which has undergone great changes. Today, hospitals are secularised, scientific-care institutions which are becoming more complex and expensive and through which, sooner or later, pass all citizens. They must be known about for a good service to be provided. Good will is not enough.

2. Hospitals are a key place for the new evangelisation. The Church has the challenge and the opportunity to illuminate with the values of the Gospel and her rich tradition the meaning of the fundamental events of the existence of those who live in hospitals, and to contribute to a clarification of the serious human, social and ethical problems which arise within hospitals. A world of this kind requires today better witnesses and masters or teachers.

3. Pastoral work in modern hospitals is not an easy task. It is tiring and can wear out or stress people. The secularised and technologised environment which reigns within them, religious indifference, the rapid coming and going of sick people and the constant changeover of patients to be treated and care for, the excessive burden of work for the staff and chaplains, the daily contact with people who suffer etc., all require training, commitment, realism, dedication and care.

4. Training today is even more necessary and urgent because a notable number of chaplains were not in their time prepared for, and made capable of, working in the world of pastoral care in hospitals.

5. Only good training will allow chaplains to acquire the necessary ability to co-operate in centres with people and services which take care of sick people.

3. The Goals and Contents of the Training of Chaplains

John Paul II has said that 'the

profound meaning of training is that of helping priests to be and to carry out their functions in the spirit and in the style of Jesus the Good Shepherd' (*PDV*, 73). The training of chaplains has as its goal not that of defining their role but of helping them to grow and to mature in a human and Christian way, to define their own identity, and to enable them to carry forward in an effective way their mission'.[1]

a. Helping to Grow and Mature in a Human and Christian Way

The first objective of training is the *very person of the chaplain.*

Training must help chaplains to know their own internal world and their own therapeutic resources, to meet their difficulties and their afflictions, and to reconcile themselves with their own death.

Training must favour within chaplains the growth of mature personal feelings. This is because love for God is especially communicated through the witness and the expression of one's own life.

Amongst the qualities which chaplains must cultivate the following may be listed: deep respect for other people, readiness to help, understanding, knowledge of one's own gifts and limitations, an ability to establish a person to person relationship, flexibility, discretion, and a readiness to co-operate and work in a team.[2]

b. Defining the Identity of Chaplains

'The presbyter, through his presence at the side of the sick person, *is a sign of the presence of Christ,* not only as a minister of the sacraments but also as a special servant of his peace and his consolation'.[3]

As a servant of the Word, chaplains proclaim the truth of the Gospel, applying it to the concrete circumstances of life in hospitals. As a servant of the sacraments, chaplains preside over the Eucharist and celebrate repentance and the anointing of the sick (*PO*, 6). As pastors, sent by their bishops to the hospitals, they have the mission of exhorting Christian brotherhood amongst all those who work in hospitals or pass through them, and of creating a pastoral group or team, whose actions they co-ordinate by being a bond of unity.[4]

Training must help chaplains: 1. To feel that they are ministers of Jesus Christ, the sacrament of the love of God for man, every time that they are mediators and alive instruments of the grace of God towards men (*PDV*, 73). 2. To mature an awareness of the fact that their ministry is radically ordered to summoning the family of God as a brotherhood which is animated by charity and to bring it to the Father through Christ in the Holy Spirit (*PDV*, 74). 3. To grow and develop within themselves an awareness of their own participation in the salvific mission of the Church (*PDV*, 75).

The careful contemplation of Jesus, of his life, of his words and his actions, his way of addressing himself to suffering and death, his way of acting and his relationships with people, and especially with sick people, will help chaplains to define their own identity as pastors and their style of presence next to the sick person and to faithfully carry out their mission in the name of the Lord as friends and servants of life.[5]

3. Supporting and Completing Chaplains so that in an Effective Way they can Carry out their Missions

Training does not end with itself – it has a practical goal. This is to prepare chaplains for the effective carrying out of their mission. So, what is their mission and what are their functions?

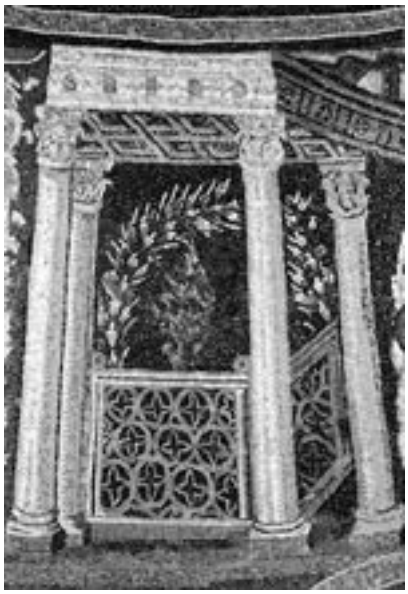
3.1 To evangelise life and health, illness and care, suffering and death, as well as assistance.

Training must enable chaplains to enter into deep dialogue with the culture of the world of health and health care and offer the meaning which the Gospel, theology and the Magisterium give to such important subjects as: the defence of and care for life; the human contents of a real quality of life; health as a responsible endeavour directed towards the overall growth of the person; the ecological meaning of health understood as harmony with the environment in which life develops and grows; the Christian vision of the physical dimension of man and the government of the body; the human and Christian possibilities of illness; the human and Christian value of the giving of blood and organs; the human and Christian experience of old age; and the human and Christian sense of dying.[6]

3.2. Visiting and Accompanying the Sick Person and his or her Family in the Process of his or her Illness, Treatment and Care, and or Death

The sick person, and his or her family, is the privileged centre of the attention, care and pastoral concerns of chaplains. Visiting and accompanying the sick person must be based upon the same approach as Jesus and offer to the sick person the help that he or she needs in order to live out the various stages of his or her illness in a good way in order struggle in a worthy way for his or her health and where this occurs to draw near to death with hope.

Training must help chaplains to know in profundity the interior world of the sick person, his or her needs, and particularly his or her spiritual and religious needs. It



must in addition help them in relation to the pastoral help which has as its objectives:

– To better understand the needs of the sick person, take on board his or her questions, understand those questions which are not expressed, and share his or her hopes, trials and joys.

– To learn the art of listening and communication.

– To know how to begin, deepen, and conclude pastoral encounters.

– To teach us to walk with the sick person, and to follow and respect his or her rhythms.

– To know the resources of Christian faith on order to live out illness and death.

Some sick people must have priority for chaplains: the terminally ill, the mentally ill, those suffering from AIDS, the elderly, sick people belonging to other denominations or faiths, patients far from home, and non-believers. Training must prepare chaplains in relation to specialised pastoral care for these sick people.

3.3. Celebrating Life in the Sacraments of the Sick: Reconciliation, Communion, Anointing and the Viaticum

The celebration of the sacraments occupies a privileged place in the mission of chaplains. Training must help them to understand the theological meaning of each sacrament, to organise their celebration with real zeal, to discern the motivations of the sick person at a pastoral level, to seek out the right moment at which to bring about the active participation of the sick person, to explain to him or her the expressive wealth of each sacrament, to encourage where possible celebration in community form, and above all else to stimulate the nearness of believers, family relatives, workers and volunteer workers who are near to sick people and thereby 'sacralise' with their service and work the presence of the healing and saving Christ.[7]

3.4. The Pastoral Care of the Staff of the Centre

Pastoral care directed towards health care workers, and particularly Catholic health care workers, is an obligation of primary importance which, however, chaplains at times neglect. Training must make them able to look after such health care workers with regard to their spiritual and religious needs. In addition it should help them to discover in a better way the meaning of their work and the Christian contents of their healing service; support their efforts to further humanise assistance to the sick and share with them the serious problems which are raised in the exercise of their profession. Where health care workers are members of religious orders, chaplains must dedicate special attention, seeing their presence in positive terms as a gift and relying on their co-operation in the activities of pastoral service.[8]

3.5. The Offering of Ethical Consultation to Sick People, their Family Relatives, the Staff, and the Services of the Centre when they are asked to do so

In hospitals, every day, the great questions of science are raised, and ethical problems concerning sick people, their relatives, health care workers, and the various departments and services, present themselves. Training will help chaplains to make a contribution to their understanding and their clarification, taking part in the training of health care workers and offering that ethical consultation which is asked for, as well as actively taking part in those committees of ethical assistance which are now growing up and spreading in hospitals.[9]

3.6. Co-operating in the Progressive Humanisation of Health Care

The humanisation of health care is one of the great concerns today in the hospital world. Training must prepare chaplains so that they can co-operate through: the provision of the humanising force of the Gospel values (compassion, respect, mutual help, solidarity, free self-giving, reconciliation...), the human and competent discharge of their own functions, care for those who must suffer the effects of dehumanisation, and participation in and support for actions which are promoted in hospitals to obtain more human treatment, etc.[10]

3.7. The Promotion of a more Intense and Fecund Relationship with Parishes

The Christian community which is present in a hospital centre, which receives and cares for sick people, does so as an extension of the community from which they come and to which they return. It is thus necessary to achieve a more intense relationship and greater co-operation between both, and even more to realise that the stay of sick people in such a centre will be increasingly short in duration. Training will help chaplains to discover this need and to break this isolation, which brings benefits to nobody at all.[11]

3.8. To Construct the Christian Community within the Hospital

Chaplains have the task of building up and presiding over the Christian community within hospitals. It is the helping body of Christ within which every member of that community develops their own charism and places it at the service of their mission – evangelisation. Training must make chaplains able to pass from pastoral work where they almost alone are the protagonists to pastoral activity effected in communion with, and with the co-responsibility of, the members of the pastoral service, the Christians who work in hospitals, and voluntary workers as well. In the same way, training must prepare chaplains to organise the pastoral care which has been planned, carried out and assessed within a group where all participants, respecting their own charisms, should work to overcome individualistic tendencies and temptations.[12]

4. The Characteristics of Training

Each form of training has characteristics which differentiate it from other forms. Those characteristics which make the achievement of its goals and objectives must be chosen. Taking this reality into account, the specific and on-going training of chaplains must have the following characteristics. Such training must be:

Overall and integral: it must involve all the dimensions of training and act to support authentic spirituality, careful human and theological grounding, and effective technical ability in communication and organisation. *Something which begins with life* (the exercise of the ministry), illuminates life and returns to life.

Theoretical-practical: it must link action and knowing because in acting we express what we learn

and in our action we can constantly learn.

Active and personalised: it must involve the subject of the formative process who is really its protagonist.

Participated in and shared: it must be gained through personal study and reflection carried out within a group.

Transforming: it must involve help being a factor in the growth of the person and the identity of the chaplain, his attitudes, his knowledge, and his weaknesses.

Contextualised: it must be something adapted to concrete situations, the health care context in which chaplains work, and to the needs of the recipients of the ministry.

Gradual: it must be a process which favours and fosters a harmonious growth, which respects the rhythms of people and which does not seek to do things too quickly.

It must have Christ as a model, the Spirit as a guide, and sick people as teachers.

5. Levels or Stages of this Training

Training in pastoral care in health involves various levels which then unfold during the subsequent stages of that training.

5.1. The Initial Training of Seminarists

This has two principal objectives: 1. To sensitise seminarists in relation to pastoral care in health and to make them suited when they become presbyters to carrying out the mission which the Church has entrusted to them – that of 'looking after the sick and the dying with care and concern' (*PO*, 8). 2. To take advantage of the opportunities offered by contact with sick people to clarify, assess, strengthen or modify a life choice, that is to say their vocation. 'the training of pastoral care in health', John Paul II writes, 'is for the candidates to the priesthood an authentic school of life and a secure means by which to achieve personal growth because it is directly based upon the example of Christ the Physician'.[13]

In the study plans pastoral care in health does not appear as a specific subject but its themes and elements are present in certain subjects such as Holy Scripture, Christology, the sacraments and liturgy, anthropology, philosophical and moral ethics, and pastoral care.

In practice some seminaries offer a basic initial training through conversations, encounters, and short courses, and promote pastoral experiences in the field of the sick – visiting them, bringing the communion to them, taking part in fields of work or voluntary work during holiday periods...

Every summer in Spain since 1995 a theoretical-practical course on pastoral care in health has been held. This has been very well received by the candidates involved who have also given a very positive assessment of it. The initial training of seminarists in this pastoral field can be a nursery for future chaplains, something which is increasingly necessary if we take into account the average age of chaplains today, which indeed is advanced.

5.2. The Specific Training of Chaplains

It is right to recognise that over recent years initiatives and activity of a training character have increased in number. This is the result of greater awareness and greater commitment on the part of chaplains, to the impetus given to training by the various bodies of pastoral care in health and the associations of chaplains, to the institutions which are being created to provide training in this pastoral field, and to the training requirements of our hospital centres.

It is also true, however, that often priests are sent to hospitals without suitable training, and in some case without a vocation, and that they are left to look after themselves. This has a negative effect both upon the evangelising presence of the Church in hospitals and upon the priests themselves who experience being immersed in an unknown world which for them is at the least foreign and at times hostile where they have to engage in activity for which they do not feel prepared. It is self-evident that this situation is a serious one and that it is necessary to find a remedy to it.

In countries with an Anglo-Saxon culture (the United States of America, Canada, the countries of central and northern Europe, the Philippines etc.) specific training is a requirement in order to practice as a chaplain and has characteristics which derive from the socio-cultural climate, from ecumenical sensitivity, and from a pragmatic spirit. These countries place greater emphasis on the Word, on pastoral dialogue, on an apprenticeship based upon experience, on the professionalisation of the chaplain, on openness to interdisciplinary co-operation, and the organisation of pastoral service. They use the training model called CPE ('Clinical Pastoral Education') which sees training as a constant process of growth in three domains: the *personal* domain, being oneself, growing in an awareness of the weak and strong aspects of one's own personality and with a gradual filling in of the 'dark zones'; the *professional* domain, knowing how to do good well; and the *theological* domain, reflecting theologically on one's own experience and discovering the spiritual needs of people, trying to see with them the signs of the presence of God in human events.[14]

In countries with a Latin culture (of the European-Mediterranean area and those in Latin America) specific training is not an obligatory requirement in order to be appointed a chaplain but it is a need to which an answer should be given. The training model is not that of Clinical Pastoral Education, although some of its characteristics in adapted form are now being incorporated.

In the Spanish Church we have made a great effort over recent years to increase the awareness and facilitate the training of chaplains. After a survey in which the training requirements were set out, a training plan was drawn up which included a programme of subjects, the holding of one or two annual courses at a national level to reflect upon those subjects, and the distribution of information material to examine these subjects through personal study and reflection in meetings and in diocesan meetings. This was begun in 1983 and beginning with the third year the courses were opened to members of religious orders working in health care and to members of the laity who were be-

ginning to work in the services of pastoral care. The development of each subject begins with an analysis of the reality followed by biblical and theological illumination of it, and ends with a pastoral answer. The methodology employed links the exposition of doctrine with active personal and group work. In 1987 the bishops of the Episcopal Pastoral Commission published a report entitled 'pastoral directions in religious assistance in hospitals' which contains a favourable assessment of the development of hospital pastoral care.

5.3. The Permanent Training of Chaplains

Permanent training has amongst other goals the following specific objectives: 1. To offer mutual help through the communication of one's own experiences and reflections. 2. To face up to the risks which pastoral work in hospitals runs – routine, inner tiredness, exaggerated activism etc. 3. To acquire up-dating on aspects and subjects of training so as to be more effective. Permanent training is effected through personal study and by taking part in periodic meetings, study-days, seminars or courses, experiences undergone together, spiritual exercises, activity directed towards the permanent training of members of the clergy, and so forth.

At the present time various instruments are utilised. They are:

Specialised reviews or journals such as *Dolentium Hominum*, *Aumôniers d'Hôpitaux*, *Insieme per Servire*, *Labor Hospitalaria*, *Camillianum*, *Horizonte Médico*, *Selare*, etc.

5.4. The Training of Trainers

The growing demand for training and the improvement of its quality require specialists who are well trained in matters relating to pastoral care in health. Today there exist suitable institutions for such requirements. Amongst these there stand out the International Institute of Health Care Pastoral Theology "Camillianum". This is a centre of the Camillian fathers which was approved by the Holy See in 1997 and which provides theological training and pastoral practice for the world of health and health care. Its results have already been observed in our local Churches. It confers academic titles (diplomas and doctorates in the theology of pastoral care in health) and with its various activities it has helped to give rise to a new culture of life in order to make the field of health and health care a privileged place of evangelisation. This is the first and so far the only higher theological institute of its kind which has been established.

6. Some Proposals

The training of chaplains is the task and the responsibility of chaplains, as it is of the bodies of the Church which deal with pastoral care in health in the dioceses, in the bishops' conferences, and in the Holy See. I would like to present, after the above observations, a number of practical proposals. They are as follows:

1. The carrying out of an in-depth study of the present-day situation in relation to the training of chaplains.

2. The creation of a service which stimulates co-operation and co-ordination between the various institutions connected with the training of those engaged in pastoral care in health, and which gives an impulse to, and stimulates, the exchange of training experiences, programmes, documents, and other elements connected with training.

3. The giving of greater relevance in seminary training programmes to the theoretical and practical contents of pastoral care in health.

4. To ask for and facilitate the initial and permanent training of chaplains and all the personnel and staff of pastoral service, and the provision of support to them in the carrying out of their mission.

5. Support for the establishment of schools, training centres in pastoral care in health, and other initiatives directed towards the training of chaplains and other people engaged in providing pastoral care.

6. The permanent stimulation of theological-pastoral reflection in relation to the fundamental events experienced in the world of health and health care – health, illness, suffering, death, assistance, forms of treatment and care, questions of justice etc., involving bible experts, theologians, catechists, and specialists in pastoral work, in addition to secular health care workers, associations for sick people, and other experts in this whole field.

7. The decisive promotion of integrated pastoral services for priests, members of religious orders, and members of the laity who work in a team, with the provision of the wealth and the complementary advantages and benefits of their respective charisms.

8. The establishment of an international association of chaplains.

I hope and wish that these proposals will soon become a happy reality as a result of the efforts and co-operation of everybody, so that pastoral services in hospitals are qualified and ecclesial services which are co-ordinated with the other services which are provided and with the pastoral work of the Church as a whole.

I would like to finish with the words of a priest who is a friend of mine. These words were provoked by the death of a sick woman whom he looked after in a pastoral sense:

'Yesterday, when I greeted you... do you remember? I held your hands in mine. I said to you: "they are very cold". And you answered: "You always have warm hands. You are the pastor". Without knowing it, you gave me one of the most beautiful definitions of priesthood. To be a priest means 'to always have warm hands'. It means, in a selfish and egotistical world, to bring warmth to very many people who die of cold because they do not receive love. You yourself died thanking God for the fact that you felt surrounded, until the end, by the love of your dear ones.

In taking your leave of me I said to you "goodbye". And you answered me: "goodbye until the next life!" And to my surprise and amazement you raised your right hand, made three signs of the cross in the air and gave me your blessing. I left your home with my eyes swollen with tears. I will never be able to forget that blessing which was as surprising as it was unexpected. I will always carry it in my heart as a valuable relic because this blessing will remind me that my office as a priest is to bless everyone, to forgive, to serve, to work for others... and will carry in my hands the ever alight flame of a sincere and selfless love'.

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Notes

[1] Comisión Episcopal de Pastoral, *La asistencia religiosa en el hospital* (Edice, Madrid, 1987), n. 178.

[2] Comisión Episcopal de Pastoral, *op. cit.*, n. 179.

[3] *Ritual de la Unción y de la Pastoral de Enfermos, Orientaciones dcotrinales y pastorales del episcopado espaZol*, n. 147.

[4] Comisión Episcopal de Pastoral, *op. cit.*, n. 147.

[5] For the basic questions of the study-week on 'the Catholic chaplain in pastoral care and health on the threshold of the third millennium' organised by the Pontifical Council for Health Pastoral Care and held on 22-23 November 1999, see *Dolentium Hominum*, n. 44, 2000/2.

[6] Departamento de Pastoral de la Salud, *Congreso Iglesia y Salud* (Edice, Madrid, 1995), n. 175.

[7] Departamento de Pastoral de la Salud, *op. cit.*, n. 165.

[8] Departamento de Pastoral de la Salud, *op. cit.*, n. 166.

[9] Comisión Episcopal de Pastoral, *op. cit.*, nn. 120ss.

[10] Comisión Episcopal de Pastoral, op. cit., nn. 135-136.

[11] Departamento de Pastoral de la Salud, *op. cit.*, n. 167.

[12] Departamento de Pastoral de la Salud, *op. cit.*, n. 164.

[13] JOHN PAUL II, 'Speech to the Plenary Assembly of the Pontifical Council for Pastoral Assistance to Health Care workers', Rome, 9 February 1990.

14. A. Pangrazzi, *Girasoles junto a sauces* (Sal Terrae, Santander, 1999), pp. 61-62.

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