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Antonia D'Aniello
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Magisterium

Addresses by the Holy Father

We are Certain that Life will Triumph

THE SPEECH OF JOHN PAUL II TO THOSE TAKING PART IN THE SEVENTH GENERAL ASSEMBLY OF THE PONTIFICAL ACADEMY FOR LIFE AT THE AUDIENCE GRANTED ON THE MORNING OF 3 MARCH IN THE SALA CLEMENTINA.

1. It is always a great pleasure for me to meet you, distinguished members of the Pontifical Academy for Life. The reason today for this opportunity is your annual general assembly, which has brought you to Rome from various countries. I extend my cordial greetings to each of you, worthy friends who make up the family of this Academy which is so dear to me. I extend a particular and respectful greeting to your President, Prof. Juan de Dios Vial Correa, whom I thank for his kind words expressing your sentiments. I also greet the Vice-President, Bishop Elio Sgreccia, the members of the Executive Council, the staff and benefactors.

2. You have chosen a topic of great interest as the theme for your assembly's reflection: "The Culture of Life: Foundations and Dimensions". Its very formulation already expresses your intention to focus on the positive and constructive aspect of the defence of human life. During these days you have been asking yourselves about the necessary foundations for promoting or revitalizing a culture of life, and with what elements to propose it to a society marked – as I recalled in my Encyclical *Evangelium vitae* – by an increasingly widespread and alarming culture of death (cf. nn. 7, 17).

The best way to overcome and defeat the dangerous culture of death is to give firm foundations and clear content to a culture of life that will vigorously oppose it. Although right and necessary it is not enough merely to expose and denounce the lethal effects of the culture of death. Rather, the inner tissue of contemporary culture must be continually regenerated, culture being understood as a conscious mentality, as convictions and actions, as the social structures that support it.

This reflection seems all the more valuable if we consider that culture influences not only the behaviour of individuals but also legislative and political decisions, which in turn facilitate cultural trends which, unfortunately, often impede the authentic renewal of society.

Culture, moreover, orients the strategies of scientific research, which today more than ever is able to offer powerful means that unfortunately are not always used for man's true good. On the contrary, at times research in many fields even seems to turn against man.

3. Therefore, it is appropriate that you wished to clarify the foundations and dimensions of the culture of life. With this in mind, you stressed the great themes of creation, showing clearly how human life must be seen as God's gift. Man, created in the image and likeness of God, is called to be his free co-worker and, at the same time, to be responsible for the "stewardship" of creation.

You have also wished to reaffirm the inalienable value of the personal dignity of every individual from conception to natural death; you revisited the theme of bodiliness and its personalistic meaning; you focused your attention on the family as a community of love and life. You dwelt on the importance of the communications media for a far-reaching dissemination of the culture of

life, and the need to be involved in a personal witness to it. You have also recalled how, in this area, everything that encourages dialogue should be pursued, in the conviction that the full truth about man supports life. The believer is sustained in this by an enthusiasm rooted in the faith. Life will triumph: this is a sure hope for us. Yes, life will triumph because truth, goodness, joy and true progress are on the side of life. God, who loves life and gives it generously, is on the side of life.

4. As always happens in the relationship between philosophical reflection and theological meditation, in this case too the word and example of Jesus, who gave his life to conquer death and to give man a share in his resurrection, are also an indispensable help. Christ is the "resurrection and the life" (Jn 11:25).

Reasoning from this perspective, I wrote in the Encyclical *Evangelium vitae*: "The Gospel of life is not simply a reflection, however new and profound, on human life. Nor is it merely a commandment aimed at raising awareness and bringing about significant changes in society. Still less is it an illusory promise of a better future. *The Gospel of life* is something concrete and personal, for it consists in the proclamation of the very person of Jesus. Jesus made himself known to the Apostle Thomas, and in him to every person, with the words: 'I am the way, and the truth, and the life' (Jn 14:6)" (n. 29).

This. is a fundamental truth that the community of believers is called, today more than ever, to defend and promote. The Christian message about life, "written in the heart of every man and woman, has echoed in every conscience *"from the beginning"*, from the time of creation itself, in such a way that, despite the negative consequences of sin, t can also be known in its essential traits by human reason" (*Evangelium vitae*, n. 29).

The concept of creation is not only a splendid message of revelation, but also a sort of profound intuition of the human spirit. Likewise, the dignity of the person is not only an idea deducible from the biblical statement that man was created "in the image and likeness" of the Creator, but a concept rooted in his spiritual being, by which he shows that he is a being who transcends the world around him. The body's claim to dignity as a "subject", and not simply a material "object", is the logical consequence of the biblical concept of the person. This is a unified concept of the human being, which has been taught by many currents of thought from medieval philosophy to our times.

5. The commitment to the dialogue between faith and reason can only strengthen the culture of life, combining the dignity and sacredness, freedom and responsibility of every person as indispensable components of his very existence. Along with the defence of personal life, the environment must also be protected: both have been created and ordered by God, as the natural structure of the visible world itself confirms.

The great issues concerning the right to life of every human being from conception to death, the efforts to promote the family according to God's original plan, and the urgent need, now felt by all, to protect the environment in which we live represent an area of common interest for ethics and law. Particularly in this field, which involves the fundamental rights of human society, what I wrote in the Encyclical *Fides et ratio* applies: "The Church remains profoundly convinced that faith and reason mutually support each other; each influences the other, as they offer to each other a purifying critique and a stimulus to pursue the search for deeper understanding" (n. 100).

The radical nature of the challenges posed

to humanity today by the progress of science and technology, on the one hand; and by the progressive secularization of society, on the other, demands an impassioned effort to reflect more deeply on man and on his existence in the world and in history. It is necessary to show a great capacity for dialogue, for listening and for proposing, so that consciences may be formed. Only in this way will it be possible to create, in a just and united way, a culture based on hope and open to the integral progress of every individual in the various countries. Without a culture that safeguards the right to life and promotes the fundamental values of every person, it is impossible to have a healthy society, nor can peace and justice be guaranteed.

6. I pray that God will enlighten consciences and guide everyone involved at various levels in building the society of the future. May they always make the protection and defence of life their primary goal,

I express my heartfelt and grateful appreciation to you, distinguished members of the Pontifical Academy for Life, who spend your energies in serving such a noble and demanding goal. May the Lord support you in your work and help you to fulfil the mission entrusted to you. May the Blessed Virgin strengthen you with her motherly protection.

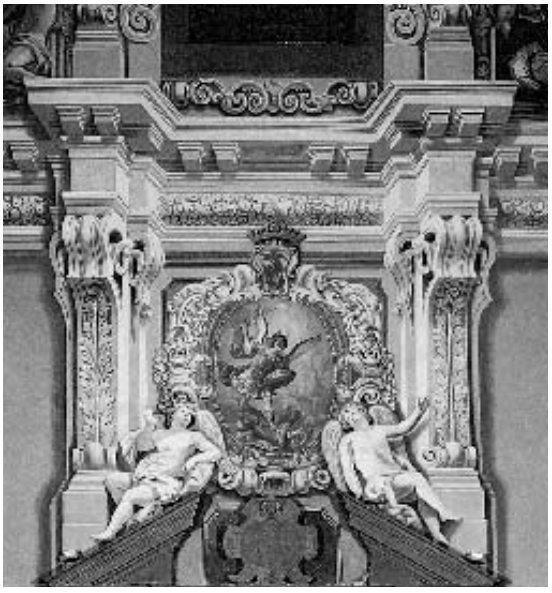
The Church is grateful to you for your lofty service to life. For my part, I would like to accompany you with my constant encouragement, confirmed by a special Blessing.

A Handicap Invites us to Overcome all Forms of Selfishness

FOR THE 30TH ANNIVERSARY OF THE FAITH AND LIFE MOVEMENT, WHICH OFFERS SUPPORT AND ASSISTANCE TO THE HANDICAPPED, THE HOLY FATHER SENT A MESSAGE TO ITS MEMBERS AS THEY GATHERED IN LOURDES TO CELEBRATE THEIR FOUNDATION

To my Sons and Daughters of the *Faith and Light* Movement

l. In this Holy Week of the first year of the new millennium, you have come to the Grotto of Massabielle on the occasion of the 30th anniversary of the foundation of your movement, and I greet you and the I greet you with affection and the assurance of my prayers. Mary herself invites you to rekindle your desire to “come and drink at the source”; she leads you, as she once led Bernadette, to the encounter with her Son. In Lourdes, the love of Jesus and Mary for the weakest appears with unique power, inviting you to give thanks to God for the marvels the Lord has wrought in you. I encourage you to renew and strengthen your



faith, and to live every day with a sense of mission.

2. Those of you who have handicaps are the very heart of the great family of *Faith and Light*. Your life is a gift from God and makes of you witnesses to the true life. If your handicap sometimes brings you difficult trials, you often live, in Claudel's expression, with "enlarged souls in chained bodies". Dear friends, you are a precious treasure of the Church, which is also your family, and you have a special place in the heart of Jesus.

3. For 30 years, with boldness, courage and perseverance, *Faith and Light* has not stopped reminding people of the eminent dignity of every human person. We can be grateful for the hope and confidence which so many individuals and families have found in the movement. To those who assist the handicapped I give heartfelt thanks for the irreplaceable work they do every day in the service of those who are often forgotten by our society, and I thank them especially for the happiness they bring. In this way they bear witness to the fact that the joy of living is a hidden fountain which flows from trust in God and in Mary, his Mother. I wish to extend a special greeting to Jean Vanier and Marie-Hélène Mathieu, who for a long time have devoted themselves to improving the lives of handicapped people and advancing their cause.

4. Dear brothers and sisters, your presence in Lourdes is also a call to Christians and to civic leaders to understand better that a handicap, even when it calls for care, is above all an invitation to overcome all forms of selfishness and to commit ourselves to a new brotherhood and a new solidarity. As I recalled, during their Jubilee in Rome, the handicapped call "into question understandings of life linked only to personal satisfaction, appearances, efficiency" (*Homily*, 3 December 2000, n. 5). They call on all the members of society to give moral and material support to parents of handicapped children. While there is an ever growing tendency to eliminate before birth a human being who may be handicapped, the activity of *Faith and Light* stands out as a prophetic sign in favour of life and in favour of the priority due to the weakest members of society.

5. In your great diversity, coming as you do from 75 countries, your experience is a truly ecumenical one. The presence together in Lourdes of different Christian confessions, Catholic, Orthodox, Anglican and Protestant, testifies, on the basis of your common faith in the risen Christ, that every individual is a gift from God, with inalienable dignity and rights. It shows too that despite a handicap, it is possible to live with happiness.

6. With affection I invoke upon you, upon those accompanying you and upon those who could not come, the strength of the risen Lord; may he grant each one of you courage and joy to continue the mission of bearing witness to God's love in the world. Following the example of Bernadette, may you be ever more receptive to the Good News, which humanity so greatly needs, and may you make it bear ever greater fruit. Entrusting you to the maternal tenderness of Our Lady of Lourdes, I cordially impart to you my Apostolic Blessing.

From the Vatican, 2 April 2001

May the Step of those Called to Stoop down to Care for and to Treat the Wounded and Suffering Man, like the Good Samaritan, be Swifter

THE ADDRESS OF THE POPE TO THE PARTICIPANTS AT THE MEETING PROMOTED BY THE NATIONAL OFFICE FOR PASTORAL CARE IN HEALTH OF THE ITALIAN BISHOPS' CONFERENCE WHO WERE RECEIVED AT AN AUDIENCE ON SATURDAY MORNING, 12 MAY, IN THE PAUL VI HALL. THE MEETING, WHICH TOOK PLACE ON 10-12 MAY, ADDRESSED ITSELF TO THE SUBJECT: 'THE ITALIAN CHURCH IN THE WORLD OF HEALTH: IDENTITY AND NEW PATHWAYS'.

1. I am very happy to extend my welcome to all of you, who during these days have reflected on the presence of the Church in the world of health, of illness, and of suffering. I greet first of all Cardinal Camillo Ruini, President of the Italian Bishops' Conference, and Msgr. Javier Lozano Barragán, President of the Pontifical Council for Health Pastoral Care, and I thank them both for their cordial words. I also greet the other Archbishops and Bishops present, especially Msgr. Alessandro Plotti, the Archbishop of Pisa and the Vice-President of the Italian Bishops' Conference, and Msgr. Benito Cocchi, the Bishop of Modena and the President of the Episcopal Commission for the Service of Charity and Pastoral Care in Health of the Italian Bishops' Conference.

I also extend my greetings to all those people who are ill and suffering, to their families, and to those who provide them with care and treatment. As I wrote in my Message of this year for the World Day of the Sick, 'I really wish in my mind, every day, to be at the side of patients, their family relatives, and health care staff' (n. 3).

This meeting of yours, significant for many reasons, is to be placed on the journey undertaken by the Italian Church to achieve an increasingly active promotion of pastoral care in health. I encourage you to follow on this path so that pastoral care in health may be recognised as having all its strength of evangelical witness, in full faithfulness to the mandate of Christ: 'Go, preach the Kingdom of God and heal the sick' (cf. Lk 5:1-2; Mt 10: 7-9; Mk 3:13-19).

2. You have gathered together to investigate the meaning and the ways in which this mandate of Christ can be implemented today. From a careful discernment of the present-day socio-cultural realities, there will certainly emerge concrete indications upon which must be based the presence of the Church in the field of caring for and looking after health, improving its quality and identifying for it new pathways of apostolic penetration.

It is useful in relation to this to remember, as I wrote in the apostolic letter *Novo Millennio Ineunte*, that 'this is not a matter of inventing a new programme. There is already a programme: it is that which has always existed, present in the Gospel and in the living Tradition. It is centred in the ultimate analysis on Christ himself' (n. 29).

And in the Message for the Eighth World Day of the Sick, held during the Great Jubilee of the year 2000, I observed: 'Jesus did not only take care of and heal the sick, he was also an untiring promoter of health through his salvific presence, his teaching, his action...In him the human condition demonstrated its redemptive countenance, and the deepest human aspirations found realisation. He wants to communicate this harmonious fullness of life to the men of today' (n. 10). Yes: Jesus came so that all men 'may have life and have it more abundantly' (Jn 10:10). And which context, more than that of health and suffering, awaits the

preaching, the witness and the service of the Gospel of life?

Imitating Christ, who took upon himself the 'suffering' countenance of man to make it 'glorious', the Church is called to follow the way of man, especially if he is suffering (cf. *Redemptor Hominis*, 7, 14, 21; *Salvifici Doloris*, 3). Her action comes to the infirm person so as to listen to him, take care of him, alleviate his trials, and open him to the understanding of the meaning and the salvific value of pain.

Never can one insist enough, and you have done this during your meeting, on the need to place the person at the centre of things, both the person of the sick man and the person of health care workers.

3. The Church appreciates how much others work in this field and offers to public structures her contribution to respond to the needs and requirements of an overall care and treatment of the person.

In this the Church is moved and sustained by a vision of health which is seen not as mere absence of illness but as a tendency towards a full harmony and a healthy equilibrium at a mental, spiritual and social level. The Church proposes a model of health which is based upon the 'health-giving salvation' offered by Christ: an offer of 'overall' and 'integral' health which heals the sick person in his entirety. The human experience of illness is illuminated in this way by the light of the paschal mystery. The crucified Jesus, experiencing distance from the Father, shouts out to Him his request for help, but in an act of love and filial trust he places himself in His hands. In the Messiah crucified on Golgotha the Church contemplates humanity extending trustingly its suffering arms to God. She draws near to those who are in pain with compassion and solidarity, making the feelings of divine mercy her own. This service to men afflicted by illness postulates a close co-operation between health care workers and pastoral workers, spiritual assistants and health care voluntary workers. How valuable, from this point of view, is the action of the various ecclesial associations of health care workers, both of a professional kind – medical doctors, nurses, pharmacists – and of a more specifically pastoral and spiritual kind!

4. In this context, the religious institutions which – loyal to their own charism – continue to play an important role in this sector, are deserving of a special mention. I ask these institutions to safeguard and to render increasingly recognisable their charisms in present situations, whilst thanking them for the witness they offer with generosity and competence, albeit amidst by no means few difficulties.

Theirs is a public service, and I strongly wish and hope that it will never fail to have the right and due recognition from the civil authorities. This is a service which requires, moreover, strong and convinced investment in the field of the specific training of health care workers. These are 'works of the Church', the heritage and diaconate of the gospel of charity for those who are in need of care and treatment. The support of the whole ecclesial community for such works should never fail to be forthcoming.

Dear brothers and sisters! Here is a privileged context in which the Church is called to bear witness to the presence of the resurrected Lord. To all those who are involved in it I would like to repeat what I wrote in the above-mentioned apostolic letter *Novo Millennio Ineunte*: 'Let us go forward with hope! A new millennium opens up before the Church like a vast ocean on which to venture out, counting on the help of Christ' (n. 58). At the beginning of this century may the step of those called to stoop down to care for and to treat the wounded and suffering man, like the Good Samaritan, be swifter. May Mary, who in heaven maternally guards over those who are afflicted by pain, be the constant support of those who dedicate themselves to its alleviation!

With such feelings, I most willingly bestow upon all of you a special Apostolic Blessing.

Ninth World Day of the Sick

Sydney
11 February 2001

The Holy Father's Letter to the President of the Pontifical Council for Health Pastoral Care

To My Venerable Brother
Archbishop Javier Lozano Barragán
President of the Pontifical Council
for Health Pastoral Care

In the peace which comes from God, I greet you and all who are gathered in Saint Mary's Cathedral in Sydney for the Eucharistic Sacrifice that is the very heart of the Ninth World Day of the Sick. I ask you to convey to Cardinal Edward Clancy and to the Church in Sydney and throughout Australia the assurance of my closeness in prayer as you meet to reflect on how the new evangelization needed at the beginning of the Third Christian Millennium must respond to the many complex questions arising in the field of health care, always in the light of the Cross of Christ, in which human suffering finds "its supreme and surest point of reference" (*Salvifici Doloris*, 3l).

Few areas of human concern are as subject to the profound social and cultural changes affecting contemporary life as health care. This is one of the reasons why in 1985 I established the body which has become the Pontifical Council for Health Pastoral Care, over which you diligently preside. Down the years, the Pontifical Council has rendered an invaluable service not only to those directly involved in Catholic health care, but to the wider community as it grapples with the many issues which have become still more pressing in the time since the Council was established. For that service, I give fervent thanks to Almighty God.

At the dawn of the new millennium, it is more urgent than ever that the Gospel of Jesus Christ should permeate every aspect of health care, and therefore I welcome the choice of theme for this World Day of the Sick: "The New Evangelization and the Dignity of the Suffering Person". Evangelization must be new – new in method and new in ardour – because so much has changed and is changing in the care of the sick. Not only is health care facing unprecedented economic pressures and legal complexities, but at times there is also an ethical uncertainty which tends to obscure what have always been its clear moral foundations. This uncertainty can become a fatal confusion, manifested as a failure to understand that the essential purpose of health care is to promote and safeguard the well-being of those who need it, that medical research and practice must always be tied to ethical imperatives, that the weak and those who may seem unproductive in the eyes of a consumer society have an inviolable dignity that must always be respected, and that health care should be available as a basic right to all people without exception. Regarding all of this I would apply to the work of the Pontifical Council and the discussions of your Conference what I said in my recent Apostolic Letter *Novo Millennio Ineunte* at the close of the Jubilee Year: it has become increasingly important "to explain properly the reasons for the Church's position, stressing that it is not a case of imposing on non-believers a vision based on faith, but of interpreting and defending the values rooted in the very nature of the human person" (n. 51).

The World Day of the Sick has a vital word to say, and the Pontifical Council has an indispensable role to play, in the Church's mission of proclaiming the Gospel of life and love to the world.

As you gather on this day dedicated to Our Lady of Lourdes, in the Cathedral dedicated to Mary Help of Christians, I commend you and Cardinal Clancy, the Pontifical Council for Health Pastoral Care and all taking part in the World Day of the Sick, to the loving intercession of Mary Most Holy, the Woman whom the Church invokes as "Health of the Sick". As a pledge of joy and peace in her Son, the Redeemer of the world, I gladly impart my Apostolic Blessing.

From the Vatican, 18 January 2001

JOHN PAUL II

Do not Forget those Who Lack Health Care

THE SPEECH OF THE HOLY FATHER AT THE ANGELUS OF SUNDAY 11 FEBRUARY WHEN ADDRESSING THE FAITHFUL WHO THRONGED ST. PETER'S SQUARE FOR THE USUAL APPOINTMENT OF THE SAYING OF THE SUNDAY PRAYER.

Dear Brothers and Sister!

1. Today, the liturgical memorial of Our Lady of Lourdes, the *World Day of the Sick* is being celebrated. The place designated this year for the significant event is Sydney, Australia, where Archbishop Javier Lozano Barragán, President of the Pontifical Council for Health Pastoral Care, went with his assistants. Every diocesan community moreover, is turning its attention to the sick and to health-care workers. In St Peter's Basilica the traditional Eucharistic celebration will also take place this afternoon, with Cardinal Camillo Ruini presiding. At the end of Mass I myself will come down to meet the sick and pilgrims attending.

In my message for this World Day, published on 22 August last year, I reflected on the theme: "*The New Evangelization and the Dignity of the Suffering Person*". Hospitals, centres for the sick or the elderly and every home where human suffering is present are privileged settings for proclaiming the Gospel message of hope. It is therefore important at the beginning of the third millennium to give new energy to the Church's age-old involvement in the world of health care, a genuine workshop for the civilization of love.

2. Looking at the current world situation, I cannot forget that many, too many, brothers and sisters still lack necessary health care. This is a grave injustice which urgently demands efforts on everyone's part, starting especially with those have greater political and economic responsibilities.

On this significant occasion, I would like to give credit to everyone, individuals, religious institutions and non-governmental organizations, who devote themselves with admirable care to the service of the sick and the suffering. I am thinking specifically of the host of men and women religious who work along with many lay people at hospitals and small health-care centres in the poorest countries amid problems and conflicts, risking their lives to save those of their brethren. I encourage them all to persevere in this praiseworthy task, which in many nations is leading to a vast and providential sensitising of consciences.

3. Let us now turn our gaze to the Blessed Virgin. The cathedral of Sydney, where solemn Mass is being celebrated, with Cardinal Edward Bede Clancy, Archbishop of that city, presiding in my name, is dedicated to St Mary *Auxilium Christianorum*, "Help of Christians". For nine years, in various parts of the world, this appointment with suffering and hope has been renewed under the sign of Our Lady of Lourdes. Let us entrust to her the sick of the whole world and all who put their professional skill and sometimes their whole lives at their service.

The Sick are a World of Hope and Joy

THE SPEECH OF JOHN PAUL II TO THE THOUSANDS OF SUFFERING PEOPLE GATHERED TOGETHER ON SUNDAY AFTERNOON, 11 FEBRUARY, IN THE VATICAN BASILICA FOR THE CONCELEBRATION OF THE EUCHARIST PRESIDED OVER IN THE NAME OF THE POPE BY THE CARDINAL VICAR, CAMILLO RUINI, ON THE OCCASION OF THE NINTH WORLD DAY OF THE SICK.

Dear Brothers and Sisters!

1. Today, 11 February, we have come together as we do every year for this customary gathering in the Vatican Basilica. My thoughts naturally turn to the grotto of Massabielle, where every year so many people pause in prayer at the foot of the statue of the Immaculate Conception. And, precisely in Mary's name, I greet all of you who have come for the Eucharistic celebration and for the evocative candlelight procession which recreates the characteristic atmosphere of Lourdes. I also greet those who have promoted and organized this always moving Marian event.

I first greet the Cardinal Vicar and the Bishops present; I also greet the directors of Opera Romana Pellegrinaggi and all the priests, religious and lay people who are taking part in the national pastoral-theological convention on the theme: "The Local Church, Pilgrimage and Traditio Fidei".

I greet you in particular, dear sick people, and with you, the organizers and volunteers of UNITALSI, a commendable association that cares for you, especially on pilgrimages.

2. Dear sick people and volunteers, your presence has special meaning, since we are now celebrating the *World Day of the Sick* for the ninth time. I still remember last year's celebration. We were in the intense spiritual atmosphere of the Great Jubilee, and the witness of faith given by those who took part made a deep impression. The generous acceptance of the Lord's will by those who are suffering is always a great lesson of life. As I have said on other occasions, the Church relies heavily on the support of those who are tried by illness: their sacrifice is sometimes little understood, but, when combined with intense prayer, it has a mysterious efficacy for the propagation of the Gospel and the welfare of the whole People of God.

Dear brothers and sisters, today I would like to express again my deep gratitude to you for your silent mission in the Church. May you be firmly convinced that it gives extraordinary power to the progress of the entire Ecclesial Community.

3. This evening, in the evocative setting of this gathering, we want to feel in communion with our brothers and sisters meeting in Sydney, Australia, for the World Day of the Sick. The theme chosen for the event, this year is: "The New Evangelization and the Dignity of the Suffering Person". This is a theme on which it is important to reflect, because physical and spiritual pain mark everyone's life more or less deeply, and it is necessary that the light of the Gospel also illumines this aspect of human existence.

In the Apostolic Letter *Novo millennio ineunte*, which I signed on the closing day of the Jubilee, I invited all believers to contemplate the face of Jesus. I wrote in that Letter that "in contemplating Christ's face, we confront the most paradoxical aspect of his mystery, as it emerges in his last hour, on the Cross" (n. 25).

You in particular, my sick friends, understand how paradoxical the Cross is, because you are allowed to feel the mystery of pain in your own flesh. When your strength fails because of a serious illness, projects you have long cherished in your heart are abandoned. In addition to physical suffering, there is often spiritual suffering due to a sense of loneliness

which grips the individual. In contemporary society a certain culture considers the sick person a troublesome hindrance, failing to recognize that he makes a valuable spiritual contribution to the community. It is necessary and urgent to rediscover the value of the Cross we share with Christ.

4. At Lourdes Our Lady said to Bernadette on 18 February 1858: "I do not promise you will be happy in this world, but in the next". During another apparition, she invited her to turn her gaze to heaven. Let us listen again to these exhortations of our heavenly Mother as if they were addressed to us: they are an invitation to evaluate earthly realities correctly, knowing that we are destined for eternal life. They help people patiently to bear adversity, sufferings, and sickness, in the perspective of paradise. At times some have thought of paradise as an escape from daily reality; on the contrary, the light of faith makes the harsh experience of suffering better understood and thus more knowingly accepted. St Bernadette herself, harshly tested by physical illness, exclaimed one day: "Cross of my Saviour, holy Cross, adorable Cross, in you alone I place my strength, my hope and my joy. You are the tree of life, the mysterious stairway that joins earth to heaven, and the altar on which I want to sacrifice myself by dying for Jesus" (M. B. Soubirous, *Carnet de notes intimes*, p. 20).

5. This is the message of Lourdes, which so many pilgrims, healthy and sick, have accepted and made their own. May the Virgin's words bring interior comfort to you, suffering brothers and sisters, to whom I once again offer my fraternal solidarity. If you docilely accept God's' will, in your illness you can be a word of hope and even of joy for many people, since you tell our contemporaries, who are often restless and unable to find meaning in pain, that God has not abandoned them. In living your situation with faith, you bear witness that God is near. You proclaim that the Lord's tender and loving closeness ensures that there is no season of life that it not worth living. Illness and death are not realities to flee or criticize as useless, but both are stages on a journey.

I also wish to encourage all who dedicate themselves zealously to caring for the sick to continue in their precious mission of love and find in it the inner consolation which the Lord grants to those who become Good Samaritans for their suffering neighbour.

With these sentiments, I embrace you all in the Lord and cordially bless you.

United to Christ the Suffering Become Ministers of the New Evangelisation

THE HOMILY OF CARDINAL EDWARD BEDE CLANCY, SPECIAL ENVOY OF THE HOLY FATHER FOR THE WORLD DAY OF THE SICK, AT THE CONCLUSION OF THE CELEBRATIONS

We are still living in the gleam of the Great Jubilee. But this is something which is now mixed with the dawn of the new millennium. Pope John Paul II presented the blessings of the year of the Great Jubilee in his Apostolic Letter *Novo Millennio Ineunte.* In this Apostolic Letter he observes the great flowering of Jubilee exercises and initiatives which has taken place in the dioceses and parishes throughout the world, but he dedicates his reflections and thoughts to events which have taken place in Rome, or in which he has been personally and immediately involved. These are events which naturally have a universal value.

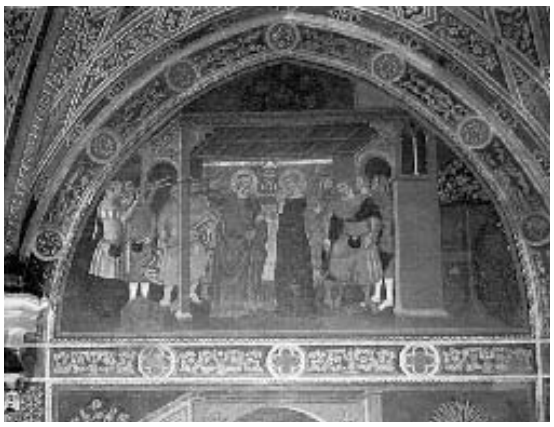
The Pope observes the request for forgiveness in the name of the whole of the Church for the errors committed by her sons and her daughters down the centuries – something he calls the purification of the memory of the Church. He observes the witness provided by so many martyrs of our times; the pilgrimage character of the Jubilee year demonstrated by so many pilgrimages, in particular carried out by young people, to Rome and the tombs of the Apostles; the Eucharistic Congress; the ecumenical appointments and meetings; and his memorable pilgrimage to the Holy Land. He sees in the Holy Year and all its activities

throughout the world a vivid expression of the presence, the mystery, and the countenance of Christ. Remembering the words that certain Greek pilgrims addressed to the Apostle Philip – "we want to see the Christ" – the Holy Father raises the question: 'is it not perhaps the task of the Church to reflect the light of Christ in every historical period in order to make his face shine forth to the generations of the new millennium as well?' Christ is everything for us, He is 'our way, our truth and our life', everything is captured in Him, all of us are united with Him and united with each other like organs of the same mystical body.

This total assimilation and incorporation in Christ by which he becomes our totality and our end, our alpha and omega, is the constant theme of the readings of today. In the first reading the Prophet Isaiah lyrically describes the saviour who is to come: 'the people who have walked in darkness have seen a great light; those who dwelt in a land of deep darkness on them light has shined...For to us a baby is born, to us a son is given...'(Is 9:1-6).

The words of Isaiah are echoed by those of St. Paul who writes to the Ephesians: 'He has chosen us out, in Christ, before the foundation of the world, to be saints, to be blameless in his sight, for love of him; marking us out beforehand (so his will decreed) to be his adopted children through Jesus Christ. Thus he would manifest the splendour of that grace by which he has taken us into his favour in the person of his beloved son' (Eph 1:1-6). In the Gospels, Christ himself takes the opportunity to confirm this truth when he speaks about his mother and his relatives: "Whoever carries out the will of God, is my brother, my sister, and my mother" (Mk 3:35).

After bringing us, through his reflections on the Jubilee, face to face with Christ, Pope John Paul II then invites us with Christ and in Christ to face the future and to answer the invitations and the challenges which it presents to us. Here the Holy Father quotes the words of Christ in the Gospel according to St. Matthew: "I will be with you for all time, until the end of the world" (Mt 28:20). John Paul II goes on: 'this certainty, dear brothers and sisters, has accompanied the Church for two thousand years and has been renewed in our hearts by the celebration of the Jubilee. From it we draw a new impetus of Christian life, making it the force which inspires our journey of faith. Aware of the presence of the resurrected Lord amongst us, we now ask the same question which was addressed to Peter in Jerusalem after the speech of the Pentecost: "What should we do?" (Acts 2:37)'.



The Holy Father observes that it is not a matter of inventing a new project – in fact there is only one project: that of the Gospels and the tradition of the Church, which finds its centre in Christ himself. 'This is a project', he goes on, 'which does not change with the times and with cultures, even though it takes time and culture into account so as to have a real dialogue with them and effective communication. This project for every time is our project for the third millennium'. What awaits us 'is a splendid work of revitalisation; a work which involves us all'. The Pope then points out certain priorities such as holiness, prayer, the sacraments of reconciliation and the Eucharist, grace, and the revealed Word of God. Special emphasis is placed upon charity, and especially on *koinonia* or communion and on the teachings of Vatican Council II. Just as Christ invited Peter to throw the net in again, even though he had worked all night without success, so the Holy Father invites us to engage with faith and courage – without being worried by the disappointments of the past – in this work of the revitalisation of the Church of the new millennium: it is the Christ of the Great Jubilee who is guiding us.

The Pope emphasises that all baptised people, without any kind of exception, are called upon to take part with zeal in this new and blessed initiative. In this way he directs our attention to the teaching of St. Paul regarding the unity and the diversity of the Church, a reality represented by the metaphor of the body – one head and many organs. 'For this reason', says the Pope, 'the Church of the third millennium must encourage all baptised people and all people who have received first communion to be aware of their active responsibility within the life of the Church'.

At this point the World Day of the Sick requires us to ask ourselves about the place of sick people and those who take care of them in this new initiative of revitalisation. By the words 'sick' and 'afflicted' we mean all those who suffer because of mental or physical ill-

ness and those who suffer because of the weaknesses and limitations brought about by advancing years. We mean both those who suffer periodically and those who suffer permanently; those who suffer in a serious way and those whose afflictions are perhaps less heavy.

One thing is certain: in the providential design the sick are not merely an unfortunate minority, the consequence of original sin and a burden on a Church which despite this fact tries to build up the Kingdom of God. We should not, that is to say, think of them as a negative factor in the mission of the Church. This could be also deduced solely from the number of people who are involved: in basic terms who is not sick for at least one moment in their lives? But even more it can be deduced from the importance of the sick and the afflicted in the earthly mission of Jesus. A large part of his time was dedicated to healing the sick: 'His fame spread throughout Syria and thus they brought to him all the sick, troubled by various illnesses and pains, the possessed epileptics and paralytics; and he healed them' (Mt 4:24).

The key to the meaning of the sick in the work of redemption and salvation is to be found in suffering. The work of Christ in reducing suffering, indeed, was symbolic of his forgiveness of sins: 'He took on our suffering, he took on our pain' (Is 53:4). But even more, he chose suffering for himself as a means for our redemption. For this reason, those who suffer patiently are united to Christ our Saviour in a unique and privileged way: 'I am glad of my sufferings on your behalf, as, in this mortal frame of mine, I help to pay off the debt which the afflictions of the Christ still leave to be paid, for the sake of his body, the Church' (Col 1:24). In speaking to those who suffer in his message for this World Day, the Holy Father says: 'I invite them to contemplate with faith the mystery of the crucified and risen Christ, so as to discover the loving plan of God in their own experience of pain. Only in looking at Christ 'man of sorrows well acquainted with grief' (Is 53:3), is it in fact possible to find serenity and trust'. The sick and the suffering, who are so intimately united to Christ, are through their suffering active and indeed key ministers of the new evangelisation. Experience lived out with faith is thereby sanctified.

And if those who suffer become one with Christ, the same is true of those who take care of them. They continue the mission of Christ by bringing relief, understanding, recovery and encouragement to the sick and at times by performing human miracles through their

knowledge. In this technological age, however, it is above all else up to them to bring that personal warmth and that love which embraces every human being as a son of God and heir to the kingdom of heaven, and to recognise Christ himself in the sick person: "I was sick", Jesus said, "and you visited me" (Mt 25:35).

The suffering and care for those who suffer are two parallel and interdependent apostolates. They draw their life force directly from the Gospels and make Christ present in our world as few other things do. Both are for this reason destined to play a central role in giving new life to the Church of the new millennium.

The Australian Church can boast an enviable past with respect to the apostolate of health. Immediately after the European settlement and after the restrictions on the Catholic Church had been removed, Catholic hospitals sprang up in all the large inhabited centres, above all as part of the work of religious congregations. The high standard of the hospitals and the other facilities of the pastoral care in health of the Church has always been recognised by the civil community, and Australian medical doctors and nurses are still some of the best in the world. In recent years, however, the structures of pastoral care in health of the Church, as is the case with hospitals throughout the world, have had to face up to increasing problems. There has been an amazing increase in costs; a reduced number of young people taking up the nursing profession as a religious vocation; new illnesses which threaten human life and weigh upon the resources which are available; and lastly the medical profession itself has every day to address itself to complex problems of a medical-moral character. Such are the challenges which we have discussed in these days.

With this Holy Mass, therefore, we address God in prayer and thank Him first of all for the divine help which in the past has been our trust. We also pray that He will enlighten us,

give us strength, and guide us as we accept the challenges and seize the opportunities which present themselves. In a special way we must pray for religious vocations dedicated to pastoral care in health so that they will always have a key role to play. The Holy Father, too, has emphasised the importance of prayer in favour of a close union with Christ as we enter in decisive fashion into the third millennium.

In the Catholic tradition, Mary has always been seen as the friend and patron saint of the sick, in whom, in a special way, she sees the clear image of her divine son. Mother of us all, Mary has special compassion for her sick sons and daughters. For this reason, we invoke the 'health of the infirm' and the 'comfort of the sick' in the Loretan litanies. Mary herself has demonstrated her special care for the sick and the afflicted in places such as Lourdes and Fatima. It naturally also follows that those who take care of sick people also have a special place in her heart. For this reason, it is truly appropriate that the World Day of the Sick should also be associated with a Marian sanctuary, as is the case with today's Holy Mass which we are celebrating in this beautiful mother church of Australia which is dedicated to Our Lady, the help of Christians.

Let it be remembered that this World Day is dedicated not only to the sick people of Australia but to sick people throughout the world, and on this feast of Our Lady of Lourdes we entrust all sick people, together with those who take care of them, to her maternal heart.

H.Em. Cardinal EDWARD BEDE CLANCY
Archbishop of Sydney

The Celebration of the Ninth World Day of the Sick 'The New Evangelisation and the Dignity of the Suffering Person'

SYDNEY, 11 FEBRUARY 2001

The Ninth World Day of the Sick was solemnly celebrated in St. Mary's cathedral in Sydney in Australia. As the Holy Father observed in his Message for this World Day, 'the choice of the Australian continent with its cultural and ethnic richness throws light on the close bond of ecclesial communion: it overcomes distances, and favours the encounter between different cultural identities which are made fertile by the unique preaching of salvation'. 'The new evangelisation and the dignity of the suffering person' was the theme of this Ninth World Day of the Sick, not least in order to place emphasis on the need to evangelise in a renewed way this sphere of human experience, to foster in relation to it a direction towards the overall well-being of the person and the progress of all people throughout the world.

The Pontifical Mission was led by H.Em. Cardinal Edward Bede Clancy, the Special Envoy of the Holy Father to the Ninth World Day of the Sick, and included Rev. Don Krzystof Nykiel, an Official of the Pontifical Council for Health Pastoral Care, Dr. John Gallagher, and Judge John Slattery.

Archbishop Javier Lozano Barragán, the President of the Pontifical Council for Health Pastoral Care, together with its Bishop-Secretary, Msgr. José L. Redrado O.H., led the Delegation which was made up of a group of sixteen people: Officials of the Ministry, ecclesiastical dignitaries, priests, members of religious orders, and members of the laity – all of whom are people who have always been involved in pastoral care in health.

The salient characteristic of the celebration of the Ninth World Day of the Sick was the involvement and role of the Pontifical Council for Health Pastoral Care, the Australian Episcopal Conference of Catholic Bishops, and the Australian Episcopal Commission for Pastoral Care in Health. This convergent co-operation made possible not only a suitable and successful preparation and celebration of this World Day but also constituted a special sensitising force in relation to increasingly large areas of both the faithful and of religious and secular institutions which are involved in the field of health, health care and suffering.

The Long-Term Preparations for the World Day

Announced and called for by the Message of the Holy Fa-

ther, the celebration of the World Day was the subject of a very large number of preparatory initiatives. It should be observed that the Pontifical Council for Health Pastoral Care was responsible for a capillary diffusion of the Message of the Holy Father through the bishops responsible for pastoral are in health and through the obvious means of communications (Internet, the Press, interviews with Superiors etc.), as well as the preparation of the official Manifesto of the Day and various other kinds of supports. The Vatican Radio also made live broadcasts of the principal initiatives connected with the celebration of this World Day.

The Celebration of the Ninth World Day of the Sick

The salient moments of the celebration which marked the days from 8-11 February, which culminated in the solemn concluding celebration of the Ninth World Day of the Sick on 11 February, were the following: visits to certain hospitals and clinics (8-9 February); the meeting with the Mayor of Sydney and the civil and ecclesiastical authorities (9 February); the celebration of the 'new evangelisation and the dignity of the suffering person' (10 February); and the solemn celebration which was held on 11 February.

1) *The visits to certain hospitals and clinics.* On Thursday 8 February H.E. Msgr. J. Lozano Barragán, the President of the Pontifical Council for Health Pastoral Care, with the Secretary of the Ministry, H.E. Msgr. José L. Redrado O.H., and a number of the members of the Vatican Delegation, visited Burwood Hospital, the Catholic hospital of the Fatebenefratelli, which has eighty-six beds. Here it was possible to observe how the world of health and suffering is evangelised in Australia today. The delegation was received by the Provincial and the Director of the hospital, Peter Burke, who explained what their mission had been in Australia over the last forty years. Afterwards a meeting was held with the hospital staff and personnel and visits were made to the various wards of the hospital, where the sick were comforted and all the patients received the blessing of the Holy Father.

In the morning of 9 February the Vatican delegation, led by Archbishop President Javier Lozano Barragán, visited St. Vincent's hospital, which is administered by the Sisters of Charity of San Vincenzo de Paoli. The immensity of this hospital complex was very striking. The public hospital and the private hospital, the clinic and the institute for research into cancer and transplants, are all in the same buildings. The delegation personally met the staff and personnel of the hospital as well as its patients. During this visit it could be observed that the institute for research into cancer and transplants of this complex was really in the very forefront of developments and research.

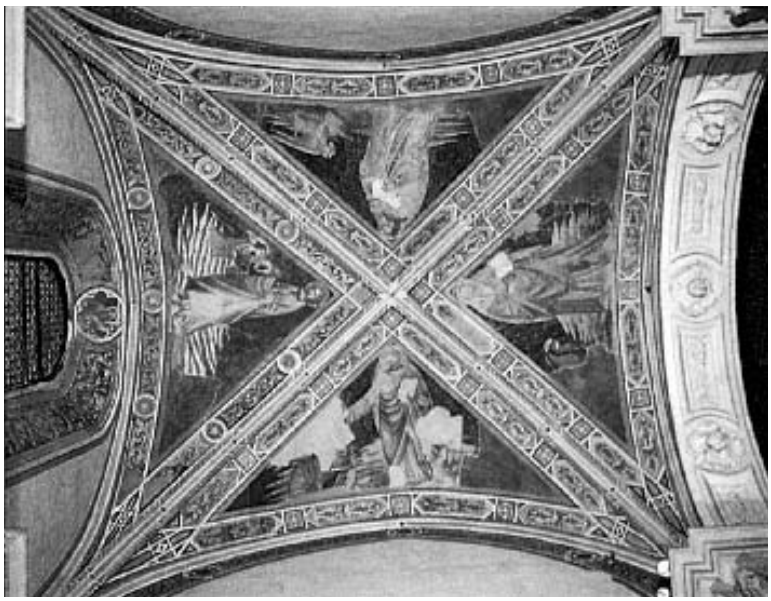
2) *The meeting with the Mayor of Sydney and certain civil and ecclesiastical authorities.* On the afternoon of Friday 9 February, the President of the Pontifical Council, H.E. Msgr. J. Lozano Barragán, and the Secretary, H.E. Msgr. Redrado, together with other members of the delegation which had been sent from Rome, met the Mayor of Sydney, Mr. Frank Sartor, in Sydney Town Hall. In addition to a cordial speech of greeting there was also an exchange of presents. H.Em. Cardinal Edward Bede Clancy, the Archbishop of Sydney and the Special Envoy of the Pope for the Ninth World Day of the Sick, as well as a number of bishops of the Australian Episcopal Conference and representatives of the episcopal commission for pastoral care in health, also took part in this meeting.

3. *The conference on the new evangelisation and the dignity of the suffering person.* On Saturday 10 February a conference on the subject of 'the new evangelisation and the suffering person' was held at the auditorium of Mary Mackilop Place in Sydney. This conference was chaired by Mr. Francis Sullivan, the Executive Director of Catholic Health Australia.

About five hundred participants were present who had come from the whole of Australia, and from Italy, Spain, the Philippines, and other countries of Asia and Oceania. They followed the papers and contributions of the conference with keenly-felt interest. In addition to the delegation led by the President of the Pontifical Council, H.E. Msgr. Javier Lozano Barragán, there were also present His Eminence Cardinal Edward Bede Clancey, the Archbishop of Sydney and the special envoy of the Pope to the celebration of the Ninth World Day of the Sick, the Archbishop of Canberra and Goulburn, Msgr. Francis Car-

roll, the President of the Catholic bishops of the Episcopal Conference of Australia, H.E. Msgr. John Joseph Gerry, the Auxiliary Bishop of Brisbane, the President of the Episcopal Commission for Pastoral Care in Health, and the Presidents and representatives of the international Catholic associations and federations actives in the world of health and health care – medical doctors, pharmacists, nurses, hospital chaplains, male and female members of religious orders, male and female nurses, and female students from faculties of medicine. The presence of figures from the world of science and learning of the country was also very marked.

The special envoy of the Pope, Cardinal Edward B. Clancy, H.E. Msgr. Francis Carroll, the Archbishop of Canberra and Goulburn and the President of the Episcopal Conference of Australia of Catholic Bishops, and Mr. Francis Sullivan, the Executive Director of Catholic Health Australia, extended a greeting to the participants.



The President of the Pontifical Council, H.E. Msgr. J. Lozano Barragán, inaugurated the deliberations and papers of the conference with an address on 'the episcopal, national and parish bodies for pastoral care in health', and in this way he linked the subject of the conference – the new evangelisation and the dignity of the suffering person – with the evangelising role and importance of these bodies.

During his paper the President stressed among other things that the idea of health 'is not only the absense of illness but is a harmonious tendency towards physical, mental, social and spiritual well-being which allows man to carry out the mission that God has destined him for, according to the stage of life in which he finds himself'. With respect to the origins of life, the basic principle continues to be that which it has always been: 'human life is a gift from God and as such it should be seen and approached. The way in which God wants this gift to be transmitted is in the highest form of love, that is to say the conjugal love of the marriage partners within a family. Everything that contradicts this principle, which also applies to euthanasia, is not acceptable from a moral point of view', continued this ecclesiastical dignitary.

Other papers followed this address given by the President of the Pontifical Council for Health Pastoral Care, all of which were directed towards making a valid contribution to the subject of the World Day.

Sister Annette Cunliffe RSG, Director of the Catholic Association of Health Care in Australia, and Father Gerald A. Arbuckle SM, Co-Director of 'Refounding and Pastoral Development' of Sydney, referred to pastoral care in health as a 'ministry which touches upon the very essence of the Church'. In addressing themselves to the subject: 'evangelising in the health system: ethical, legal and pastoral questions', the three speakers – Rev. Dr. Gerald Gleeson of the Catholic Institute of Sydney, Prof. Peter Dwyer of the University of New South Wales, and Ms. Janine Wilson, psychotherapist and lecturer in pastoral theology of the Catholic Institute of Sydney – addressed themselves to the 'way' in which the health system can be evangelised today from an ethical, legal and pastoral point of view.

In the afternoon of 10 February workshops were held on how to support and promote 'the Catholic identity in the world of health and health care', that is to say the Catholic identity of medical doctors, female nurses, chaplains, and those providing pastoral care in health.

On this subject papers were given by: Dr. Gian Luigi Gigli, President of the International Federation of Catholic Doctors (FIAMC), Anne Verlinde, the General Secretary of the International Committee of Nurses and Catholic Medical-Social Assistants (CICIAMS), and Father David Ranson, the chaplain of St. Vincent's hospital in Melbourne.

The day of study and reflection finished with certain suggestions and proposals to be made to the Episcopal Conference whose aims were to improve the presence of Good Samaritans of today in the vast field of health and suffering, which will remain for ever a special and favoured place for the new evangelisation.

4) *The celebration of 11 February.* On the morning of 11 February Archbishop Javier Lozano Barragán, the President of the Pontifical Council, accompanied by the Secretary of the Pontifical Council, H.E. Msgr. José L. Redrado, Rev. Gianfranco Grieco of the *Osservatore Romano,* Don Antonio Soto and Don Krzysztof Nykiel, both Officials of the Pontifical Council, began the

World Day with visits to a number of patients at St. Vincent's hospital. The President and the Secretary of the Ministry comforted these patients and brought them the blessing of the Holy Father; some patients were also given holy communion and provided with the sacrament of the anointing of the sick. Also in the morning of the 11 February the President of the Pontifical Council, Archbishop Javier Lozano Barragán, presided over a Holy Mass which was held in St. Vincent's hospital for those patients and health care workers who were not able to go to the cathedral. During this holy mass the Archbishop administered the sacrament of the anointing of the sick to a number of patients.

The most important moment during the celebration was the solemn celebration of the Eucharist, which took place on Sunday 11 February and was celebrated in the memory of the Blessed Virgin of Lourdes. It was presided over by the special envoy of the Holy Father for this World Day, Cardinal Edward Bede Clancy, the Archbishop of Sydney. Twenty-five ecclesiastical dignitaries were next to Cardinal Clancy, amongst whom were archbishops and bishops of the continent of Oceania and the President of the Episcopal Conference of Catholic Bishops of Australia, H.E. Msgr. Francis Carroll, the Archbishop of Canberra and Goulburn, Archbishop Francesco Canalini, the Apostolic Nuncio to Australia, Archbishop Javier Lozano Barragán, President of the Pontifical Council for Health Pastoral Care, the Bishop-Secretary of the same Pontifical Council, Msgr. José L. Redrado, H.E. Msgr. John Joseph Gerry, the Auxiliary Bishop of Brisbane, the President of the Episcopal Commission for Pastoral Care in Health, and bishops from Papua New Guinea, New Zealand, Malaysia and Ghana, as well as Officials of the Pontifical Council for Health Pastoral Care and about a hundred priests from the archdiocese of Sydney.

The celebration of the Eucharist was solemn and dignified, and 3,600 pilgrims took part in it, amongst whom were patients and the people who accompanied them. The Presidents and representatives of the international federations and associations of the world of health and health care were also present: medical doctors, nurses, hospital chaplains, male and female members of religious orders, female students from faculties of medicine, as well as a representative of the female religious of the FERS of Spain.

At the beginning of the solemn celebration of the Eucharist, from the altar of the cathedral of Sydney which is dedicated to the Virgin of Consolation, H.E. Msgr. Javier Lozano Barragán, President of the Pontifical Council for Health Pastoral Care, read in English the Message of the Holy Father John Paul II which the Pope had sent to this special occasion, and this was met by a long applause by the assembly which had gathered together in prayer. Once again the word of the Holy Father touched people's hearts and projected into the future this Church, called as she is to defend the value of life from conception until its natural end.

Cardinal Edward Bede Clancy, the Archbishop of Sydney and the Special Envoy of the Pope to the celebrations of the Ninth World Day of the Sick, in his homily summarised the whole of the Jubilee idea of the Holy Father as expressed in the Apostolic Letter 'Novo Millenio Ineunte' in order to stress once again the urgent need of beginning from Christ and with Christ to evangelise each and every field of apostolate and in a special way that of health and suffering. The Ninth World Day of the Sick, observed Cardinal Clancy, 'obliges us to ask ourselves the place of the sick and those who care for them in this new initiative of post-Jubilee revitalisation'. 'Suffering and care for those who suffer', continued the Cardinal, 'are two parallel and interdependent apostolates. They draw their life force directly from the Gospels and make Christ present in the world as few things do. Both for this reason are destined to play a determining part in the new life of the Church of the third millennium'.

A very moving moment was the administration of the sacrament of the anointing of the sick to twenty-five sick people by Cardinal Clancy, the special envoy of the Pope, by the President of the Pontifical Council, H.E. Msgr. Javier Lozano Barragán, and by the other two ecclesiastical dignitaries of the local Church who were present.

The celebration of the Ninth World Day of the Sick terminated with the solemn blessing of all the participants, and especially of sick people.

On 13 February, on the return trip to Rome, in response to an invitation of the Episcopal Commission for Pastoral Care in Health of Thailand, the President of the Pontifical Council, H.E. Msgr. Javier Lozano Barragán, accompanied by the Bishop-Secretary Msgr. Redrado and the other members of the Vatican delegation, stopped at Bangkok and went to Rayong, a city some two hundred kilometers from Bangkok, to visit a centre for the care of AIDS victims run by the Camillian Fathers. A meeting was held with the Commission for Pastoral Care in Health of the local Church led by H.E. Msgr. Lawrence Khai Saen-Phon-On, Archbishop of Thare and Nonseng, and with those in charge of the centre. During the meeting the situation of pastoral care in health in Thailand was described, and the activities carried out in the centre were also illustrated. The President-Archbishop described certain guidelines for pastoral care in health at the level of the Episcopal Conference. The following also took part in the meeting: H.E. Msgr., Adriano Bernadini, the Apostolic Nuncio in Thailand, H.E. Msgr. Lawrence Thienchai Samanchit, the Bishop of Chanthaburi, Rev. Gianfranco Crieco of the *Osservatore Romano,* and Msgr. Jean Marie Mpendawatu, Don Antonio Soto, Rev. Bernard Grasser M.I, respectively Officials and collaborator of the Pontifical Council.

The visit was concluded

with a concelebration of the Eucharist accompanied by songs and prayers and presided over in the Thai language by Archbishop Lawrence Khai Saen-Phon-On, who is responsible for pastoral care in health in Thailand. In addition to the members of the Vatican delegation, H.E. Msgr. Lawrence Thienchai Samanchai and a number of Camillian fathers from the centre also took part. This was really a joyful celebration whose real protagonists were the sick, both adults and children.

After the celebration of the Eucharist, the delegation had lunch with the directors of the centre and all the sick people present.

The Vatican delegation reached Rome in the morning of 14 February.

The logistical and transfer organisation, directed by the Under-Secretary of the Pontifical Council, Rev. Felice Ruffini M.I., with the active collaboration of the members of the general secretariat of the Ministry, meant that the various moments of the many-sided participation of the delegation in the celebration held in Sydney and the meeting in Bangkok were both comfortable and faultless.

Conclusion

1. The well organised preparation of the World Day and its successful celebration should be emphasised.

2. In participating in the days of study and prayer it was possible to observe the openness, the hospitality, and the welcome of the Australian Church.

3. It was possible to observe that pastoral care in health in Australia is developing well.

4. The participation of various groups and their immediate involvement in the unfolding of the World Day was also a fact to be noted.

5. There certainly remains over from this World Day the spirit of the celebration which will lead to greater attention being paid to sick people and the suffering, who are and will always be the *way* for the Church. At the dawn of the new millennium it is more urgent than ever before to proclaim the Gospel of life and to reaffirm the dignity of the suffering person.

6. The Message of the Holy Father, his love for the sick and the suffering, remain as an invitation to everybody and especially to all sick people of any age or condition, to abandon themselves to the paternal arms of God. It is also an invitation to be always the custodians and the Witnesses of the Gospel of life, doing good to those who suffer and doing good with one's own suffering. The Jubilee idea of the Holy Father expressed in the Apostolic Letter 'Novo Millennio Ineunte' was received with new enthusiasm: to begin again from Christ to evangelise every field of apostolate and in particular the field of health and suffering, which is the authentic *laboratory of the civilisation of love.*

Rev. KRZYSZTOF NYKIEL,
Official of the Pontifical Council for Health Pastoral Care.

Topics

Physical Pain and Moral Suffering of Everyman and the Christ-man

The Spiritual Needs of the Sick Child and his Pastoral Care

Philosophy, the Construction of a Profession

Neurological Aspects of Death

Fears and Hopes in the Face of Death

Physical Pain and Moral Suffering of Everyman and the Christ-man

A PHYSIOPATHOLOGICAL AND THEOLOGICAL INTERPRETATION: THE PHENOMENON OF HEMATOIDROSIS

PART I: A Physiopathological Interpretation of the Pain and the Suffering of Everyman

We know that from the *biological stage of physical pain* (or algos) man matures an *ethical stage* involving the internalisation of his own physical pain, which is moral pain, or suffering (pathos) which is a moment of free and conscious reactivity of his own Self which involves the will. This condition leads both everyman and the Christ-man to greater knowledge of God, and thus to an increase in Faith, the fundamental moment which tends to lead him as well to accept and bear really intense clinical situations of pain both in clinical pathologies which afflict everyman (Zucchi-Honings, 1996) and in the dying situation of the Crucifixion of the Christ-man.

The raising of the threshold of pain (= the reduction in the perception of physical pain and

Fig. 1. A theological-medical interpretation of pain and suffering. Gate control: the gate which controls the nociperceptor afferencies. Endorphins: endogenous substances of a meconic nature which have an analgesic effect.

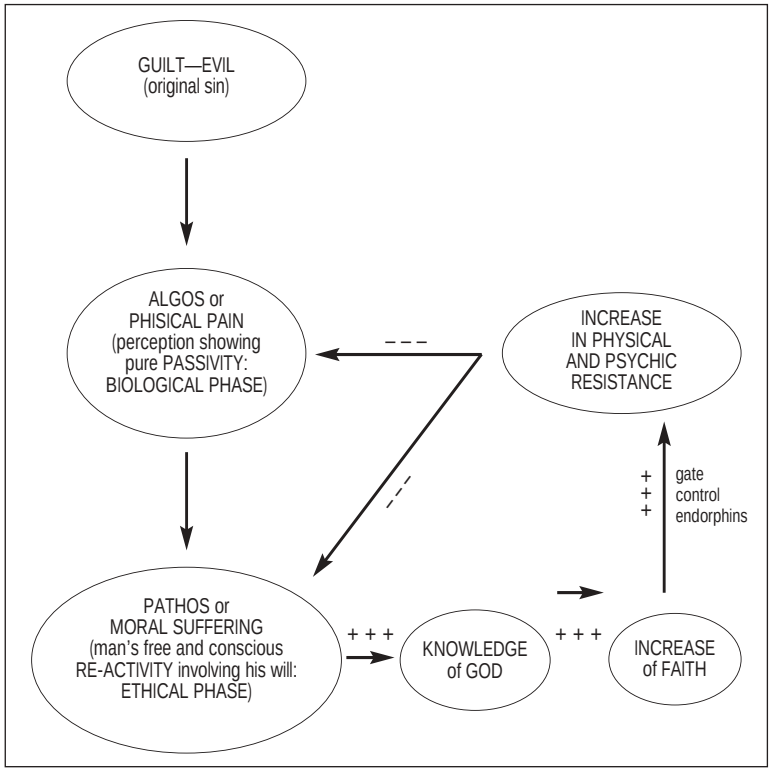


Fig. 2. A schematic representation of the principal stations of anti-nociperception.

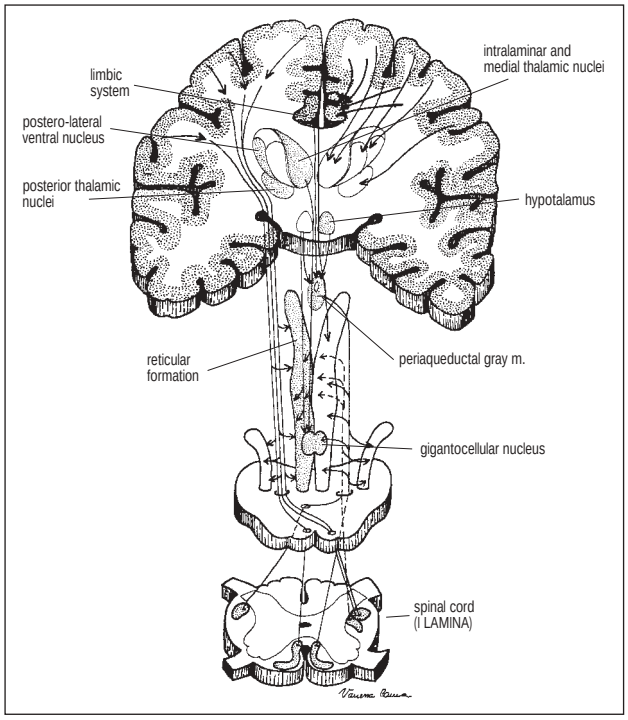
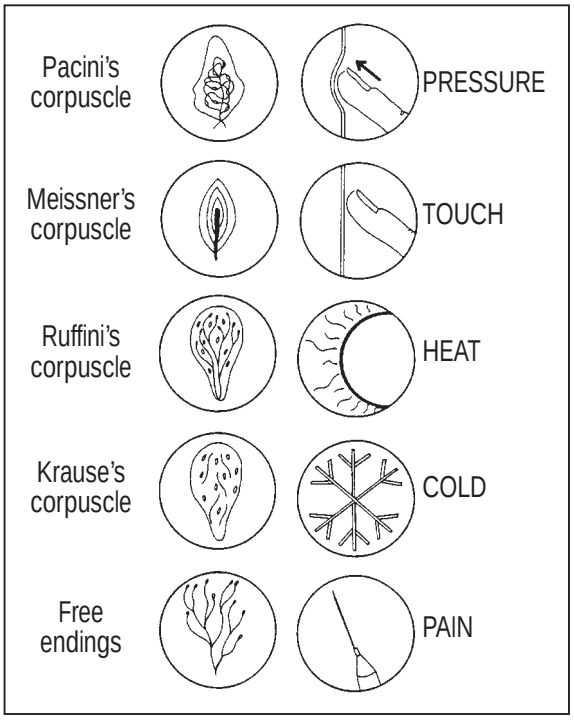


Fig. 3. A schematic representation of the sense receptors.



moral suffering) in the believer is due to an increase in the physical and moral forms of resistance which the condition of Faith is able to achieve in the organism of each individual who has a Higher Being as a point of reference (Fig. 1) (Zucchi-Honings, 1996).

The Physiopathological Mechanism of the Raising of the Threshold of Pain

The physiopathological mechanism by which the condition of faith in everyman and the Christ-man manages to raise the threshold of pain lies: (a) *neurophysiologically*, in the activation of the anti-nociperception pathways (Fig. 2) made up of the descendant inhibitor tracts which determine the closure of the gate to the pain receptor input, caused by the algogenic noxa, which begins with the various types of receptors (Fig. 3) and which follow the ascendant tracts of nociperception (the neospinothalamic tract and the paleospinothalamic tract) (Fig. 4) at the level of the different stations (Fig. 5), as is also propounded in the 'gate theory' of Melzack and Wall (1965, cf. fig. 6). b) *Neuropharmacologically*, in the release of encephalins – endogenous substances which the organism itself produces – of a meconic (morphinic) nature with an antalgenic effect, which are localised at various levels of the central nervous system (CNS) (the medial and intralaminal thalamic nuclei, the limbic system, the lateral postero ventral nucleus, the posterior thalamic nuclei, the hypothalamus, the reticular formation, the periacquaductal grey substance, and the gigantocellular nucleus) (Fig. 2).

Systems of the Organism which Interfere with Pain

Pain is a very complex noxological entity whose genesis and typology involve the action of a number of systems (Zucchi,

Fig. 4. Schematic representation of the neospinothalamic tract and the paleospinothalamic tract, pathways which lead and modulate pain to the higher centres.

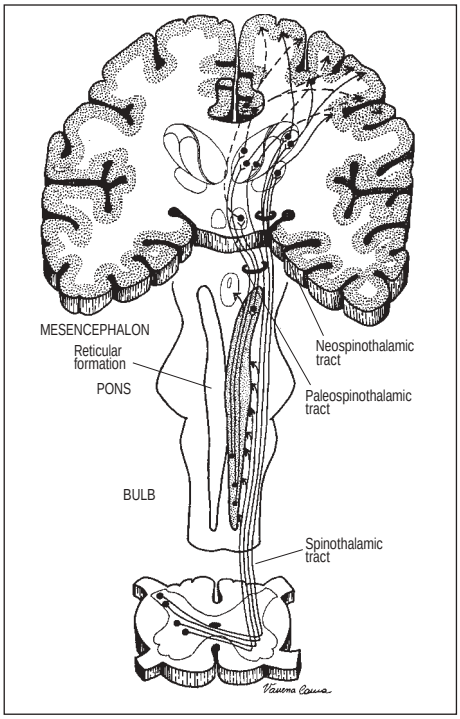
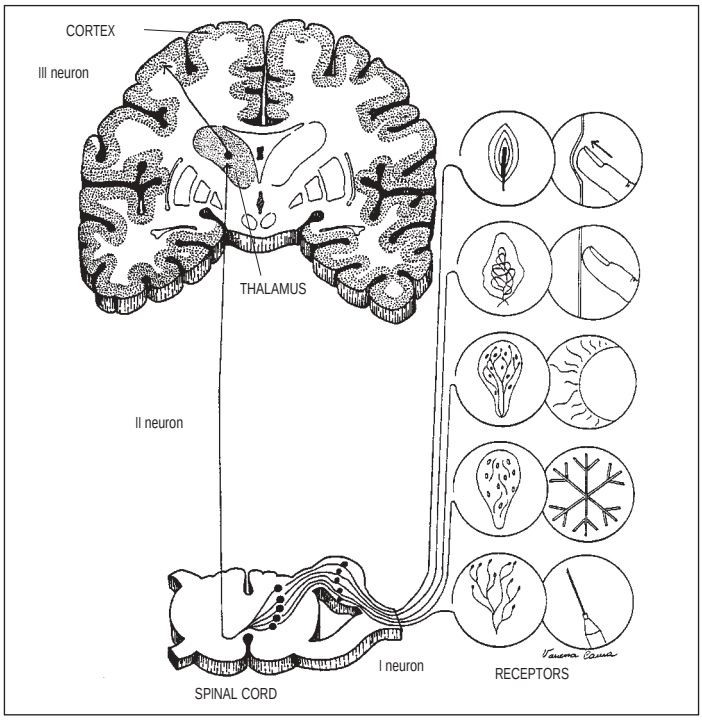


Fig. 5. Schematic representation of the stations of nociperception. (I neuron: receptor-column; II neuron: column-thalamus; III neuron: thalamus-cortex.



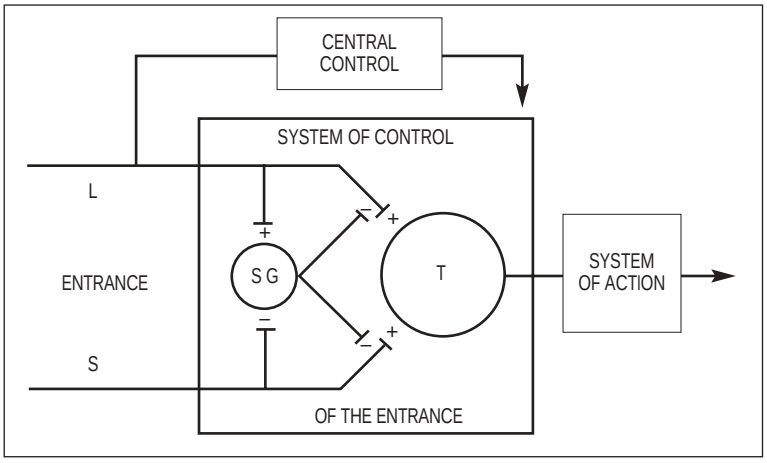
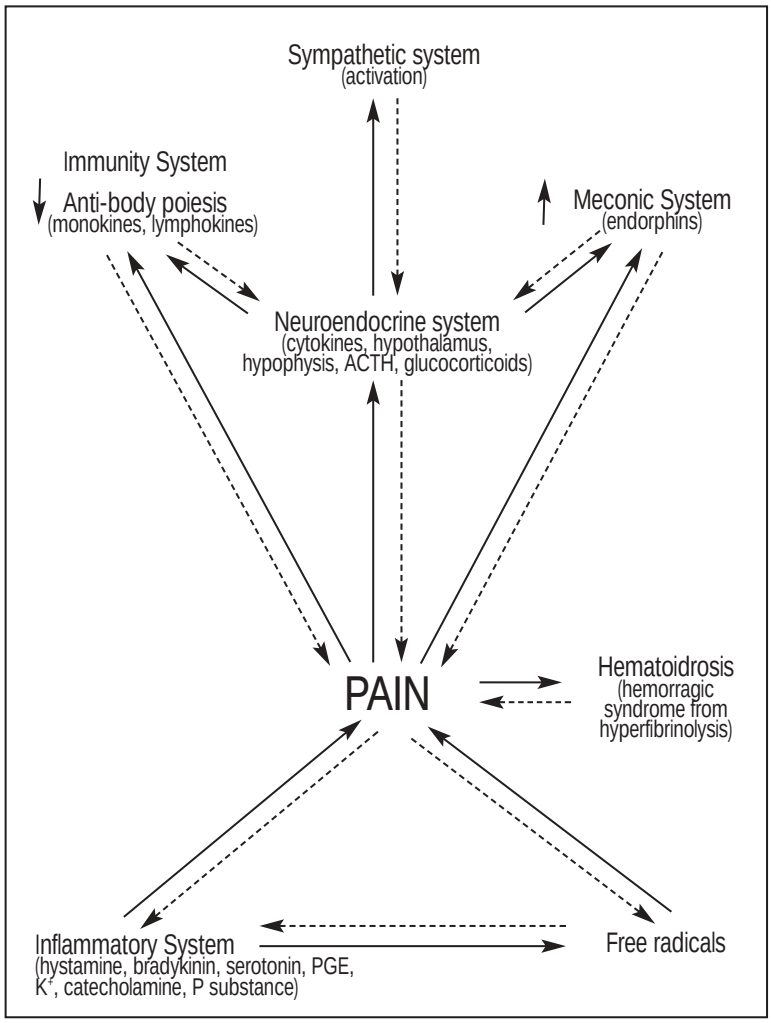


Fig. 6. Schematic representation of the 'gate control theory' of Melzack and Wall (1965).
L = afferent fibers of a large diameter; S = afferent fibers of a small diameter; SG = interferon of the gelatinous substance which determines the presynaptic inhibition of the afferent fibres which converge on the same neuron T. The activity of the interneuron (SG) is aroused by impulses led by fibres of a large diameter and inhibited by impulses led by fibres of a small diameter.

1995). The interactions between these systems and the pain symptom are often reciprocal.

Figure 7 seeks to provide a schematic view of these relationships.

Fig. 7. Systems of the organism which interfere with pain. A physiopathological interpretation of the phenomenon of hematoidrosis.



Pain and the Neurendocrine System

The relationships between the endocrine system and the other information systems of the organism – in the first instance the nervous system and the immunity system – are at the present time the object of great scientific interest (Levi Montalcini, 1995; 1996). In particular, the importance of the glucocorticoids as hormones which everywhere mediate nervous, metabolic, and immunological functions is today recognised.

Physiopathological Aspects of Glucocorticoids

The Secretion of Glucocorticoids

The suprarenal cortex is sub-divided into different zones:

1) the *glomerular zone*, which secretes *aldotesterone*;

2) the *fasciculated zone*, which secretes *glucocorticoids*;

3) the *reticular zone*, which secretes *androgens*.

This distinction, however, is not absolute because the fasciculated zone and the reticular zone make up the same functional unit. In fact, even if there exists as a rule a 'physiological specialisation' by which the fasciculated zone produces cortisol and the reticular zone produces dehydroepiandrosterone, both are able to produce the same steroids (Angeli *et al.*, 1994).

The endocrine secretion of the fasciculated zone is substantially controlled by angiotensin II.

Both the action of the adrenocorticotropin hormone (ACTH) and of angiotensin II on adrenal secretion takes place through specific receptor sites belonging to the Gs group (receptors associated with stimulatory G-proteins) (Mountjoy *et al.*, 1992). The action of stimulation exercised by the ACTH in the adrenal secretion of glucocorticoids has as its fundamental intercellular messenger the *cyclical* AMP (cAMP) (Gill, 1979). However, side by wide with the ACTH and angiotensin II, other factors exercise an activity of control on adrenal secretion. In fact, if the control of the fasciculated zone is essentially the task of the ACTH, (probably with complementary factors, amongst which the same angiotensin II), glomerular secration is governed, together with angiotensin II, also by the concentration of sodium and potassium, by the atrial natriuretic peptide (ANP), by *dopamine*, by the ACTH itself, and by other substances. The fasciculated zone, side by side with the principal stimulus of the ACTH, also feels the complementary action of other factors, amongst which angiotensin II. Our knowledge is less clear about the control of the secretion of dehydroepiandroterone-sulphate by the reticular zone. It has been advanced that the modulators of this secretion are peptides of a pituitary origin and substances from the underlying medulla by diffusion or by vascular pathways (encephalins, corticotropin realising factor (CRH), opioids, and the ACTH) (Angeli *et al.*, 1994).

The Secretion of ACTH

The pituitary secretion of the ACTH is governed by more than one factor. In particular, the most important two molecules are the CRH and vasopressin (AVP, argininvasopressin).

The CRH, in addition to the already mentioned action in relation to hyophysis, has other actions: at a hypothalamic level it inhibits the activity of other neurons secreting other realising factors, it stimulates sympathetic activity at a central level, and modulates endocrine, behavioural and neurovegatative functions. In this sense, the CRH has an important role in the reactions of adaptation to stress (Richard, 1993). The secretion

of CRH takes place for the most part at a hypothalamic level and is in its turn under the control of various molecules (acetylcolin, serotonin, catecholmine, GABA, opioid neuropeptides, and neuropeptide Y.). However, a peripheric synthesis of CRH is also recognised.

The role of 'vasopressin' (AVP) as the worker of hypthalamic control,at the present time seems to be no less important than that of the ACTH. Similarly to the ACTH, the secretion of AVP by the paraventricular neurons has more than one modulator (the adrenergic system, neurpeptide Y, GABA, the opioid system). The glucocorticoids inhibit the secretion of AVP and that of CRH (Uth, 1988).

The Pituitary-Hypothalamic Axis

The daily activity of the pituitary-hypothalamic axis has important characteristics. It is *intermittent* or *pulsating* because the episodes of secretion are broken up by periods of functional rest. A *circadian rhythm* follows as is borne out by the fact that over 70% of the production of the ACTH and cortisol takes place in the eight hours after midnight. It has a real *endogenous syncronisation* in that the cells, in vitro as well, and thus deprived of the usual specific conditions, maintain a certain rhythmic activity. Lastly, they experience an exogeneous *synchronisation* because such regulation is also modulated by external factors which act as synchronisers, such as light-darkness changeover, the rhythm of meals, and the working timetable of a person. In terms of purpose, the highest secretion which takes place in the early morning can be interpreted as an attempt to programme the organism to face up to the day in a state of full efficiency. The possibility of modulation on the basis of external stimuli suggests, on the other hand, a capacity to integrate with, and to adapt to, the environment (Angeli *et al.*, 1992, 1994).

Pain, Stress, Cytochines and ACTH

With regard to the release of the ACTH, side by side with the mechanism referred to above which recognises the CRH and AVP as fundamental mediators, and the negative feed-back due to the glucocorticoids, emphasis should be placed on the role played by two factors – *stress* and the *cytochines*.

It is known that stress in itself is not a pathological phenomenon, but a reaction of physiological and paraphysiological adaptation which prepares the way for a reaction of defence. It is equally known that a subjective individual variability exists in the sense that the same stressor can bring about variable responses in different individuals. However, the role of stress in the release of the ACTH is very important and takes place both through an increased hypothamalic release of the CRH and AVP, and through an increased pituitary response to these two substances (Gaillard *et al.*, 1987; Donald, 1994). Furthermore, according to the kind of stress which is at work, the hypothamalic microenvironment changes. For example, emotional forms of stress increase the opioid tone (Gaillard, 1987), whereas the stress induced by hypoglycemia induces a fall in the opioid inhibitory tone and a sympathetic stimulation.

At the present time it is recognised that some *cytochines* increase the secretion of the ACTH (*II-1, II-2, II-6, tumor necrosis factor or TNF alpha, interferongamma*). This idea opens up prospects of very great interest in the study of the complex relationship between the neurendocrine system, immunity, and pain. In fact, the release of cytochines can be consequent upon tissue damage, the stimulation of the immunity system brought about by factors of infection, and traumas (Imura and Fukata, 1994). In this sense, the cytochines-hypothalamus-hypophysis-glandulae suprarenalis-circuit is a physiological factor in the limitation of the damage underway involving phlogistic stimuli. This *endogenous* response is obviously connected to the psychic-physical state of the subject as a result of which, for example in poor psycho-physical conditions, the above mentioned mechanism may provide inadequate responses.

Side by side with its adrenal action, the ACTH exercises its own action also at an extra-adrenal level. It has, in fact, a melanocytostimulant activity and performs a role, whose character is still not yet clear, in the control of arterial pressure. In addition, the ACTH and some of its fragments have important effects on the central nervous system (CNS), aiding the perceptive and mnemic processes and psycho-physical performance (Angeli *et al.*, 1994).

Glucocorticoids: Peripheric Effects

The receptors for the glucocorticoids are in practice everywhere and for this reason the action of these substances takes place at more than one level. A detailed description of the peripheric effects of glucocorticoids is outside the scope of this paper. To summarise, let us remember that they have complex effects on the *lipidic, glycidic, and proteic metabolism and on the hydroelectrollytic balance*. They have an activity at the *cardiovascular* level (increase in the arterial pressure, vasoconstriction, and strengthening of the sympathetic), at the *gastroenteric* level (increase in the secretion of chloridic acid, reduction in the production of mucus), at the *respiratory* level (increase in the interaction between catecholomines and the bronchial beta-2 receptors, the synthesis of surfractant), and at the *hematological* level (erythrocytosis, leucocytosis, neutrophilia, acidopenia). For a more detailed description of these effects we refer the reader to other works on the subject (Angeli *et al.*, 1994). Instead, we will dwell here, albeit in a summarising way, on certain fundamental notions concerning the relationships which connect the glucocorticoids to the feeling of pain, that is to say their effects on the central nervous systm, their anti-inflammatory action, and their relationship to the immunity system.

Glucocorticoids and the Central Nervous System

It is believed that the glucocorticoids have an action on cerebral development in the prenatal and postnatal stage, until

puberty (Doupe *et al.*, 1982), stabilising a series of neuronal circuits which are prevently at the limbic level, and that the principal targets of these hormones are the *amygdala* and the *hippocampus*. It is also believed that the steroids perform a role of modulation in adrenergic and serotoninergic neurotransmission (Mason, 1986). On the basis of the role of the limbic system and the serotonin system in emotional and behavioural reactions, one understands how the cortisol increases the emotional state and promotes reactive impulses. This action belongs to the purpose of preparing the way for suitable reactions to stress (Angelucci *et al.*, 1991; Angeli *et al.*, 1994).

Other actions of cortisol at the level of the central nervous system (CNS) include: *psychic effects* (euphoria, insomnia, but also anxiety, depression, and psychosis); *hypoanosmia* (in chronic hypercorticalism); an *increase in the hematic flow and the stabilising of damaged neuronal activity* (after acute administration); and *neurotoxicity* (because of a chronic excess of corticosteroids) (Angeli *et al.*, 1994).

The Anti-phlogestic Action of Glucocortocoids

The clucocorticoids reduce vasal permeability, leukocytarian migration, the synthesis and the release of the phlogosis mediators in the extracellular space, and the formation of the granulation tissue (Schleimer, 1993). It should be emphasised that that anti-inflammatory action of the glucocorticoids takes place in two different ways. Indeed, some effects require high concentrations of cortisol (*pharmalogical load*), whereas the 'physiological' role of these substances must be assessed in the light of the *hypothalamus-hypophosis-glan dulae suprarenalis circuit* (see above).

Pain, the Glucocorticoids and the Immunity System

In this sphere as well, the action of the glucocortocoids must be seen both as a *physiological component* and as something which is secondary to a *pharmacological load*, and thus a load at high levels of dosage. The action of the glucocortocoids is modulatory in relation to the lymphocytes B (dosage-dependent activation or inhibition of the anti-body reaction), whereas it is inhibiatory in relation to the lymphocytes T, *macrophages* and *monocytes*, and natural killer cells (NK). In addition, the glucocorticoids have an inhibitory effect on the synthesis of cytokines and increase the genic expression of enzymes and regulatory proteins.

To summarise: *the pain stimulus, and in particular the events correlated to that stimulus (tissue damage, traumas, factors of infection) bring about a release of cytokines. These substances, in their turn, increase the secretion of the CRH and AVP at the hypothalamic level and thus the consequent pituitary release of the ACTH and the adrenal release of steroids. The setting off of the cytokine-hypothalamus-pituitary-glanduale suprarenalis circuit brings about, in definitive terms, an endrogenous analgesis-anti-phlogistic response on the part of the organism*.

Pain and the Immunity System

Forty years of research by the group led by Rita Levi Montalcini on the nerve growth factor (NGF) (NGF, 1995; 1996) have opened up new perspectives on the interactions between sensitivity to pain, the endocrine system and the immunity system. In particular, it has been demonstrated that the nerve growth factor has the possibility of interacting with many cells of the nervous, neuroendocrine, and immunity systems, thereby activating homeostatic systems which strengthen the physiological defence systems of the organism.

For this reason, with the aim of overcoming the rigid division into systems, Rita Levi Montalcini has hypothesised the existence of a neuro-endocrine-immunity system.

According to such a system, the pain stimulus provokes the activation of axonic anti-dromic reflexes with the release of substance P, the activation of mastocytes, and the release of histomin and prostoglandin. The same stimulus, through ascendant impulses in the hypothalamic tracts, activates many encephalic nuclei, above all the cholerngic ones, which have specific receptors for the NGF. This activation extends to the nuclei of the base, to the hypothalamic nuclei, to the hypophysis, to the endocrine glands, and to the sympathetic system. It is above all else the role played by the sympathetic system which constitutes one of the most original and innovative elements of this theory. Indeed, by stimulating the immunity system at its key points (the thymus, the lymph glands, the spleen), this constitutes without doubt the structure of essential connection for the working of this integrated homeostatic system.

An important work by Besedowsky reports an increase in the ACTH and glucocorticoids after the endovenous injection of interleuchin-1 (Besedowsky *et al.*, 1986). This observation laid the ground for an understanding of the connections which exist between pain, the neuroendocrine apparatus, and immunity. To summarise: *a painful event provokes the activation of the neuroendocrine response (see above) through the immunity system.* In turn, it can be perceived how alterations in the immunity system are connected to greater susceptibility in relation to pain stimuli.

Pain and Free Radicals

A tissue wound, whether acute or chronic, generates a phlogistic process which in turn sets off a series of local and general reactions of the organism. Such reactions, directed towards limiting damageand accelerating the processes of regeneration, also produce a series of damaging effects, such as *pain*. In the genesis of pain a large number of phenomena are involved (vasodilatation, exudate, the migration of leukocytes, and an increase in capillary permeability) which in turn are due to various activation reactions. These reactions include the activation of the complement system, the coagulation system, the release of prostoglandin, of serotonin, histamin

and other substances. In these reactions of activation, an important role is today attributed to the free radicals of oxygen. These radicals are thought to be released following tissue damage (the activation of the complement, leukocyte chemiotassis). *The free radicals of oxygen are thought, therefore, to be the principal agents of the sensation of pain. The actions of these substances are thought to be: vasoconstriction and platelet aggregation with local ischemia; direct nervous stimulation due to edema; quinon and prostaglandin-mediated action; acidosis; and irritation because of the release of lithic enzymes* (Cuocolo, Novelli, Peduto, Ursini, 1986).

Pain and Phlogosis

The relationship between pain and phlogosis have been in part described in the previous section. To summarise: the wounding event brings about the activation of a phlogistic process in whose genesis various reactions and systems take part (see above). The pain, therefore, is nothing else but one of the multiple effects of these reactions. In practice, therefore, the following schema comes about: *a) the wounding event; b) phlogosis; c) pain*. It should, however, be remembered that pain can also be generated outside the mechanism described above, that is to say when a wound is absent and the consquent phlogosis is absent. This is the case with *cutaneous pain caused by mechanical stimulation*, produced, for example, through the rapid introduction of a needle into the skin. In these situations the symptom of *pain* is due to the direct arousal of the mechanical nociperceptors. The result is a pricking pain (Galletti *et al.*, 1980). In these cases as well, however, side by side with the direct mechanical stimulation, the unleashing trauma can also activate the mediate-phlogosis mechanism.

With regard to the opposed relationship of 'pain as the origin of phlogosis', this relationship is implicit given, as has been seen, that the wounding event is very often a painful stimulus. In addition, the activity of the nociperceptors generates in itself local tissue modifications with vasodilatation, edema, and the release of neuropeptides such as substance P. These modifications continue beyond the initial stimulus and extend beyond the zone in which the same stimulus has been applied. In this way, the intensity and the quality of the pain are modified and amplified (Fields, 1988). It should also be remembered that pain, whether acute or chronic in nature, always generates an unfavourable psychological reaction (for the most part, anxiety in the case of acute pain, and depression in the case of chronic pain) which can contribute to bringing about a favourable climate for the conservation of the phlogistic state.

Pain and the Sympathetic Nervous System

In this case as well the relationship is complex and reciprocal. The role of the sympathetic nervous system in the genesis of pain is recognised and has been emphasised many times in the literature on the subject. One need only think of *causalgia*, a complex noxological entity, belonging to the group of *reflex sympathetic dystrophies* or *reflex algodystrophies*. This syndrome is characterised by pyrotic pain, also unleashed by stimuli of modest intensity, generally localised in a limb. Trophic alterations of the skin can co-exist, such as glossy skin, vasomotor disturbances, and bone demineralisation (Galleti *et al.*, 1980). The pain is sustained specifically by the sympathetic activity as is demonstrated by the fact that a blocking of the sympathetic afferences to the painful region brings about an immediate disappearance of the symptom (Fields, 1988).

With regard to the action of pain on the sympatic nervous system, it has been demonstrated that the action of nocuous stimuli at the level of the deep somatic structures can bring about the arousal of sense receptors by activating afferent unloading and inducing a reflexive arousing of the efferent somatic and vegetative pathways. The activation of the efferent somatic fibres brings about phenomena of muscular contraction, and as a result the further arousal of the sense receptors. The activation of the sympathetic efferents induces a direct release of noradrenalin, vasomotor phenomena, and a variation in capillary permeability. The effect is a modulation of the receptors (that is to say a variation of their threshold and forms of response). In definitive terms, modifications are created such as to perpetuate the algogenous conditions (Maresca, 1987; Procacci *et al.*, 1963).

Pain and the Meconic System

The relationship between pain and derivatives from opium has very ancient origins and the use of these substances in algogenous syndromes is still of fundamental importance. More recently, however, much has been learnt about endogenous opioid peptides. These substances are produced directly at the level of the nervous system. So far, three groups of molecules are known about, namely *encephalins, endorphins, and dinorphins*. *Encephalins* have a similar morphine action, antagonised by naloxone. They are present in the sympathetic nervous system, in the intestine, in the chromaffin cells of the adrenal medulla, and in the central nervous system. Here their highest concentration is at the level of the periductal grey substance, in the bulbous and bridge ventral areas, and in laminas I, II, V and X of the spinal column. The *beta endorphin* is, instead, highly concentrated in the hypothalmus. The *dinorphins* are to be found in the same seats as the encephalins but they have less analgesic activity. At the present

time the endogenous opioids are recognised as having an important role. Indeed, it has been demonstrated that numerous stimuli, amongst which are to be listed stress and *stimulation of the nociperceptors* activate these systems (Zoppi, 1991).

Pain and the Fibrinolytic System

It is known (Neri Serneri, Gordon) that in situations of elevated stress and intense physical pain, abnormal quantities of plasminogenic activator are released from the tissues of our organism and that these circulate. In such situations of plasmatic proteolytic activity, the principal coagulative defect is due to the presence of the products of proteolysis. These substances, which come from the same fibronogen or from fibrin, circulate in the blood, and , acting as anti-thrombins, produce an abnormal polymerisation of the fibrinogen, and at the same time they alter the platelet function. In clinical situations involving intense physical pain, both the local release of thromboplastic substances and of fibrinolythic substances is possible.

The Phenomenon of Hematoidrosis

One of the rather rare aspects which must be taken into consideration in the pain of everyman is the phenomenon of hematoidrosis.

In the 'Dictionary of the Technical Terms of Medicine' written by M. Garnier and V. Delamare, the feminine noun 'hematoidrosis', which comes from the ancient Greek words for blood and for sweat, and which in Italian is synonymous for sweat of blood, is defined in the following way: a disturbance of the secretion of sweat characterised by a red colouring of the sweat. This colouring is due to the presence of hematic pigments without red globules.

This phenomenon was present during the agony of Jesus, as described by St. Luke, who was both an evangelist and a physician: 'And now he was in agony, and prayed still more earnestly; his sweat fell to the ground like thick drops of blood'.

The etiology of hematoidrosis (Fig. 7) in everyman can be caused by intense physical pain, which is able, through a stress activation, to provoke a hemorrhage syndrome of hyperfibrinolysis which brings about the phenomenon of the hemolysis of the red globules with a successive release of hemoglobin into the plasma and then into the sweat. This event, rare in everyman, took place in the Christ-man.

PART II:
A Theological Interpretation of Pain in Christ-Man

'At the centre of the catechism we find essentially one person: that of Jesus of Nazareth, the only begotten son of the Father... who suffered and died for us and now, risen from the dead, lives for ever with us... To catachise, therefore, is to reveal in the person of Christ the entire plan of God... It is to search to understand the meaning of the actions and the words of Christ, of the signs which he worked'.[1]

In line with what has been argued and outlined in the first part of this paper, the death agony of Jesus at Gethsemani can represent the typical figure of the terminally ill person. However, his clinical terminal state, although similar to the utmost to the terminal state of *everyman*, has for the theologian the meaning of a mysterious purpose, that is to say, the salvation of sinful mankind. The Church expresses this concept in the hymn that was pronounced by St. Paul: 'Yours is to be the same mind which Jesus Christ shewed. His nature is, from the first, divine, and yet he did not see in the rank of Godhead, a prize to be coveted; he dispossessed himself, and took the nature of a slave, fashioned in the likeness of men, and presenting himself to us in human form; and then he lowered his own dignity, accepted an obedience which brought him to death, death on a cross'.[2] In line with this, the Church teaches that the Son of God made himself man to save us by reconciling us with God: it was God 'who loved us and sent us his Son as a victim of expiation for our own sins' (1 Jn 4:10). 'The Father sent his Son as the Saviour of the world' (1 Jn 4:14). 'He came to take away sins' (1 Jn 3:5)'.[3]

In the first part of this study, the physiological interpretation of the physical pain, the moral suffering, and the hematroidosis of Jesus at Gethsemani was discussed and addressed. In the second part of this paper a theological interpretation of the agony of the Christ-Man is offered to the reader.

The clinical terminal state of the dying Christ can be compared to that of *everyman*. To explain it, the scholar Pierluigi Zucchi[4] has used – in the first part of this paper, something which is more than right – empirical and theoretical data (Zucchi-Honings, 1996).[5] For this reason, in the thematic introduction, the Person of Jesus is presented as a person sent by the Father to achieve the salvation of the whole of humanity.[6] Entering *in medias res*, I would like to refer to how this is presented by St. Gregory the Great, a Pope, in a yet more specific and pertinent way, in his *Comment on the Book of Job*: 'Christ, in fact, suffered his passion and bore the torment on the cross for our redemption, although he had not committed any violence with his own hands, not any sin, nor had he any deceit on his mouth. He alone amongst all raised his pure prayer to God, because even in the very trial of his passion he prayed for his persecutors, saying: "Father, forgive them for they know not what they do" (Lk 23:34)'.[7]

With his portryal of the suf-

fering Christ, this great Pontiff made clear that every bible-based attempt by a theologian should be placed, precisely because we are face to face with a great mystery, immediately within the riverbed of faith. He is so convinced of this that he continues his argument by asking himself: 'What can one say, what can one imagine that is more pure than a compassionate intercession on behalf of those who make us suffer? Thus it happened that the blood of our Redeemer, shed with cruelty by his persecutors, was then taken on by them with faith, and the Christ was proclaimed by them the Son of God'.[8]

At this point the intention of this study of the authors becomes even clearer. *Scientific explanation* on the one hand, and *theological interpretation* on the other, are two instances which complement each other, indeed they complete each other because they reveal both the truth and the veracity of the mystery of the Incarnation of the Word of God and its salvific purpose. The phenomenon of hematroidosis provides, according to the previously expounded explanation, a surprising scientific proof of the corporeity of the Christ-man. The description furnished by Luke allows of no doubts on the matter: 'And now he was in agony, and prayed still more earnestly; his sweat fell to the ground like thick drops of blood'.[9]

Now, and this is what this theological interpretation seeks to make clear, it is a fact of faith that we are all redeemed through this blood, precisely because it was the blood of the Son of the Father-God, the blood of the Second Person of the Most Holy Trinity.

To avoid any misunderstanding on the question, reference may be made to the authentic and authoritative teaching of the Catechism of the Catholic Church: 'The name of the Saviour God was invoked only once in the year by the high priest in atonement for the sins of Israel, after he had sprinkled the mercy seat in the Holy of Holies with the sacrificial blood' (cf. Lev 16:2, 15-16; Sir 50:20; Heb 9:5, 7). 'When St. Paul speaks of Jesus whom 'God put forward as an expiation by his blood' (Rm 3:25), he means that in Christ's humanity 'God was in Christ reconciling the world to himself' (2 Cor 5:19).[10]

In this way it is evident that whoever seeks a theological interpretation of the hematoidrosis of Jesus at Gethesemani knows that he must enter into the mystery of Christ's 'vicarious or substitutive' suffering in our place. One thereby becomes aware of the great complexity of the exegesis of a phenomenon which from a scientific point of view can be encountered in clinical pathologies as well. For this reason, we should turn to the author of the Letter to the Hebrews. In order to grasp the meaning of the mystery of the atonement of our sins, through the instrument of the suffering and the agony of Christ at Gethsemani, the author invites us to turn our gaze to: 'Jesus, crowned, now, with glory and honour because of the death he underwent; in God's gracious design he was to taste death, and taste it on behalf of all'.[11] Continuing in his argument, the same inspired author brings out, specifically in the light of this observation, the extreme convenience of the passion as a chosen way of the Father for the redemption of the whole of mankind. 'God is the last end of all things, the first beginning of all things, and it befitted his majesty that, in summoning all those sons of his to glory, he should crown with suffering the life of that Prince who was to lead them into salvation. The son who sanctifies and the sons who are sanctified have a common origin, all of them; he is not ashamed, then, to own them as his breathren. I will proclaim thy renown, he says, to my brethren; with the Church around me I will praise thee; and elsewhere he says, I will put my trust in him, and then, Here stand I, and the children God has given me'.[12]

The Etiological Meaning of the Physical Pain and the Moral Suffering of the Agony of Christ

Thus we come to why the physical pain, the moral suffering of Jesus, and his death on the cross, which culminated in the phenomenon of hemotoidrosis that he experienced, were adjudged by God to be the instrument most in conformity with his compassion and fully in line with the requirements of his justice. The Catechism of the Catholic Church, in the light of the written divine word, leads us to understand the most convincing reasons for this: 'For as by one man's disobedience many were made sinners, so by one man's obedience many will be made righteous (Rom 5:19). By his obedience unto death, Jesus accomplished the substitution of the suffering Servant, who 'makes himself an *offering for sin'*, when 'he bore the sin of many' (all, B. Honings), and who 'shall make many to be accounted righteous', for 'he shall bear their iniquities' (cf. Is 53:10-12). Jesus atoned for our faults and made satisfaction for our sins to the Father'.[13]

Precisely in order to give more weight to the convenience of the 'theological' why behind the mysterious phenomenon of the hematroidrosis of Christ, two fundamental aspects are stressed: 1) the full human awareness of Jesus when faced with the horror of death; and 2) the fullness of 'sacrificial' love of the divine Dying One at Gethsemani. Here is a clarification of the point as made by the Magisterium of the Church: 'The cup of the New Covenant, which Jesus anticipated when he offered himself at the Last Supper (cf. Lk 22:19), is afterwards accepted by him from his Father's hands in the garden at Gethsemani (cf. Lk 22:20), making himself obedient unto death (Phil. 2:8; Heb 5:7-8). Jesus prays: 'My Father, if it be possible, let this cup pass from me...' (Mt 26:39). Thus he expresses the horror that death represented for hus human nature. Like ours, his human nature is destined for eternal life; but unlike ours, it is perfectly exempt from sin (cf. Heb 4:15), the cause of death (cf Rom 5:21). Above all, his human nature has been assumed by the divine person of the 'Author of Life' (Acts 3:15) , the 'Living One' (Rev 1:17; cf. Jn 1:4; 5:26). By accepting in his human will that the Father's will be done, he accepts his death as redemptive, for 'he himself bore our sins in his body on the tree' (1 Pt 2:24).[14]

What gave the mysterious

meaning, that is to say the value of universal salvation, to the human phenomenon of the hemotroidosis experienced by Jesus at Gethsemeni was his love until the end. Yes: it was precisely this love which confers the value of redemption and of atonement, of expiation and of satisfaction, on the sacrifice of Christ (cf. Jn 13:1). 'He', observes the Catechism of the Catholic Church on this point, 'knew and loved us all when he offered his life' (cf. Gal 2:20; Eph. 5:2-25).(15) By now I hope that the theological interpretation is a *luce clarius* and that it gives a universal salvific value to the phenomenon of the pain, the suffering and the blood and sweat of Jesus at Gethesemani and his death on the cross which is seen as being based on the existence in Christ of the divine Person of the Son. 'No man, not even the holiest, was ever able to take on himself the sins of all men and offer himself as a sacrifice *for all'*.[16]

The most proof-worthy confirmation of our study is to be found in the following words: 'In reality only in the mystery of the Word made flesh does the mystery of man find real light. Adam, in fact, the first man, was the figure of that future (cf. Rom 5:14), that is to say of Christ the Lord. Christ, who is the new Adam, specifically by revealing the mystery of the Father and his love also fully reveals man to man and makes him observe his very high vocation... He is "the image of the invisible God" (Col 1:15; cf. 2 Cor. 4:4). He is the perfect man who has restored to the sons of Adam the likeness to God which had been deformed immediately at the outset by sin'.[17] Here is the mysterious purpose of the Incarnation, but what it is interesting to observe is that the instrument by which the Word of God achieved this purpose was our human nature. As the Magisterium of the Catholic Church makes clear: 'because in his incarnate divine person "he has in some way united himself to every man"; in him human nature was assumed, without for this reason being annihilated; for this very reason it has been also raised within us to a sublime dignity'.[18]

In his encyclical letter *Fides et Ratio*, Pope Wojtyla observes that St. Paul, when speaking in the language of the philosophers who were his contemporaries, reaches the culminating point of his teaching and of the paradox that he wanted to express: '"God has chosen in the world... that which is nothing to reduce to nothing things that are" (cf. 1 Cor 1:28). In order to express the gratuitous nature of the love revealed in the Cross of Christ, the Apostle is not afraid to use the most radical language of the philosophers in their thinking about God. Reason cannot eliminate the mystery of love which the Cross represents, while the Cross can give to reason the ultimate answer which it seeks. It is not the wisdom of words, but the Word of Wisdom which Saint Paul offers as the criterion of both truth and wisdom'.[19]

In a similar way, the authors of this study have sought, with regard to the man of science and of technology of today's world, not only not to empty the mystery of the divine Dying One but rather at the most to fill this mystery with his universal 'salvific' love. They have done this through a scientific explanation and a theological interpretation of his physical pain, moral suffering, hematroidosis, and death on the wood of the cross.

The authors have always remembered that they are, like everyone else, somewhat similar to the disciples of Emmaus. However, when the discussion bears upon Jesus it is necessary to remember his words: 'Too slow of wit, too dull of heart, to believe all those sayings of the prophets! Was it not to be expected that the Christ should undergo these sufferings, and enter so into his glory?' (Lk 24: 15-27).

Certainly, it is not as though he himself had sinned (cf Jn 8:46). 'But', as the Catechism of the Catholic Church teaches on this point, 'in the redeeming love that always united him to the Father, he assumed us in the state of our waywardness of sin, to the point that he could say in our name from the cross: 'My God, my God, why have you forsaken me?' (Mk 15:34; Ps 22:2).[20] Having thus established him in solidarity with us sinners, God 'did not spare his own Son but gave him up for us all' (Rom 8:32), so that we might be 'reconciled to God by the death of his Son' (Rom 5:10).

Conclusion

From the present study on the physiopathological and theological interpretation of the physical pain, the moral suffering, and the phenomenon of hematroidrosis, the following conclusions may be drawn:

a) man always needs a cultural formation which takes as its starting point the salvific meaning of the passion suffered by Christ-man at Gethsemani;

b) man, in this hedonistic, pragmatic and utilitarian world, if a believer, must base and refine his own ethical formation in relation to the fundamental moments of life represented by physical pain and moral suffering to strengthen himself not only from an ethical point of view but also in physical terms, as has been brought out by the medical-theological interpretation of pain and suffering represented by figure 1 (Zucchi-Honings, 1996);

c) man must get used to accepting suffering and interpreting death as the *dies natalis* which is the path, through faith, to a new epiphanic manifestation of God.

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Explanatory note on certain terms and acronyms used in the text:

ACTH: Adrenocorticotropin hormone.

Antibody poiesis: the process involving the synthesis of anti-bodies.

Antibodies: specific substances which form within the (sero) organism after contact with external agents (antigens). In many cases they have a protective action.

Pain: 'pain is a unpleasant experience of the senses and the emotions associated with an actual or potential damage of the tissue and described with terms which refer to such damage' (definition of the Commitee for the Taxonomy of the International Association for the Study of Pain' (IASP, 1979).

Hematroidrosis: disturbance of the secretion of sweat characterised by the red colouring of sweat. This colouring is due to the presence of hematic pigments without red globules.

Hemolysis: the release of hemoglobin contained in the red globule following the breaking of its wall.

Endorphins: endogenous substances with a meconic action (similar to that of morphine) present in the organism and which are released after algogenic stimulation.

Fibrinolysis: (*fibrina* and the ancient Greek word for 'to dissolve'. Dissolving of the fibrin and by extension the dissolving of a blood clot (*thrombolysis*). This is a phenomenon which takes place normally a few days or a few weeks after the formation of the clot. When it is produced too quickly, the fibrin can cause dramatic intra- or post-operation hemorrhaging (*fibrina emorragica*), especially in thoracic surgery, or following giving birth, an abortion and/or a traumatic shock. Or lessw abundant hemorrhages (such as ecchymosis, hematurias) during the course of certain kinds of cancers (of the prostrate, the pancreas, and the stomach), of cyrrosis and/or leukemias. It is due both to the release of substances which activate the fibrinolysin and to the production by the sick tissues of a proteolytic ferment. It is at times primary but at times also secondary and reactive during the course of a syndrome of widespread intravascular coagulation.

GABA: Gammaaminobutyrric acid.

Gethsemani: the olive grove where Jesus underwent his agony.

AP: Arterial pressure.

Plasma: the liquid part of blood.

Free radicals: substances which form following various stimuli and processes (pain, phlogosis, necrosis, oxidisation, ageing). They are responsible for tissue damage. Inflammatory system: this is made up of substances: histamin, serotonin, prostoglandin) released in the organism after a wounding stimulus.

Neuroendocrine system: the system which includes various glands which secrete endogeneous active substances (hormones).

Monic system: the system of the endogeneous modulation of pain which releases endorphins.

CNS: Central Nervous System.

Società Operaria (S.O.): a cultural group of Gethsemanic spirituality founded by Professor Luigi Gedda in Rome in 1948.

Notes

[1] JOHN PAUL II, Apostolic Exortation, *Catechesi Tradendae*, 5.

[2] Phil. 2:5-8, quoted in the *Catechism of the Catholic Church* (CCC), n. 461.

[3] *CCC*, n. 457.

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[6] See above, p. 1.

[7] ST. GREGORY THE GREAT, *Commento al libro di Giobbe*, Lib. 13, 21: PL 75, 1028.

[8] *Ibidem*.

[9] Lk 22:44.

[10] *CCC*, n. 433.

[11] Heb 2:9.

[12] Heb. 2:10-13.

[13] *CCC*, n. 615.

[14] *CCC*, n. 612.

[15] *CCC*, n. 616.

[16] *Ibidem*.

[17] *GS*, n. 22.

[18] Cf. *Ibidem* and *CCC*, n. 618.

[19] JOHN PAUL II, Encyclical Letter, *Fides et Ratio*, n. 23.

[20] *CCC*, n. 603.

The Spiritual Needs of the Sick Child and his Pastoral Care

XXV NATIONAL DAY OF HEALTH, MADRID SEPTEMBER 2000

'Children love bakers more than doctors because the first provide pleasure with their pastries whereas the second provoke pain by cutting and burning' (Plato, *Gorgias* 464d-465a)

1. Children have the Right to be Evangelised

'Evangelise children. They too have the right to grow in faith. It is up to us to give. They have the right to receive: faith, hope, and love'.

These and many other slogans were repeated during the World Missionary Day for Children which was held on 30 January 1977. The child is beginning his life and is sensitive to everything that surrounds him – his family, his school, his companions... His world is an imaginary world, which is fantastic, ideal, beautiful, full of affection, but also a very fragile world. For this reason, laws and adults must respect the rights of a life which can be easily manipulated.

The United Nations Organisation has recognised and set out ten fundamental principles for the child, and they are as follows:

The rights set out in this Declaration must be bestowed upon all children, without any form of discrimination.

A child must benefit from a special position so as to be able to grow in a healthy and normal way at a physical, intellectual, moral, spiritual and social level.

A child has the right, from birth, to a name and a nationality.

A child has the right to be fed, to a dwelling, to recreation, and to suitable medical care and treatment.

A child who is in a state of physical, mental or social handicap has the right to receive the treatment, education and special care that he needs and requires given his state and condition.

A child needs love and understanding in order to achieve the harmonious development of his personality.

A child has the right to education which, at least at an elementary level, must be free and also compulsory

In all circumstances, a child must be amongst the first to receive protection and aid.

A child must be protected against every form of negligence, cruelty or exploitation.

A child must be educated in a spirit of understanding, tolerance, friendship amongst peoples, peace, and universal brotherhood.

2. The Child: an Important Figure in the Bible

The child is the object of special treatment in passages to be found in the Bible. The child is the 'crown of the elderly' (Prov. 17:6) and 'olive shoots around the table' (Psalms 128:3). Given that his life is forming and is fragile he needs further protection and support: 'You will not maltreat the orphan' (Ez 22:21). 'When Israel was young, I loved her' (Os 11:1). 'Her children will be carried in her arms, and caressed on her lap' (Is 66:12).

The child Jesus, born in Bethlehem, was presented at the temple and was obedient in relation to his parents (Lk 2:12-51), and thus the figure of the child was exalted, and at Christmas the whole of mankind would come to remember and take pleasure from not only the birth of the Emanuel but also his childhood – this is because at every Christmas we are a little bit like children.

In the preaching of the Good News, Jesus would subsequently lay stress upon the fact that children are in the condition to receive the Kingdom: 'the kingdom of heaven is theirs' (Mt 19:1), and that it was necessary to become children (Mt 18:3), to be born again and to receive the Kingdom like a child (Jn 3:5; Mk 10:15).

As one authority writes: 'the figure of the child is even seen as a 'sacrament' of the welcoming of Jesus. He who welcomes one of these children in my name welcomes me' (Mt 18:5). This is a welcoming which refers to the Father (Mk 9:37). A child constitutes the image of the small human creature, who is undefended or in a condition of need. 'When you did this to one of these smallest brothers of mine, you did it to me' (Mt 25:40). Jesus himself wants to be loved and welcomed in the form of a child...'[1]

In his preaching, Jesus constantly referred to children so that we would discover how near the Kingdom is if we have the characteristics of children – simplicity, purity of heart, humility, openness, and readiness to help.

3. The Religious Experience of the Child

'Divine things slumber in the child: the educator must awaken them' (Adrienen Necker de Saussure, pedagogue).

The French singer and song-writer Pierre Duval relates the following experience of his own family: 'In my home religion did not have any solemn character at all: we limited ourselves to saying prayers together every day. I well remember the physical position and stance my father adopted. He returned tired from working the fields with a heavy load of wood on his shoulders. After supper he bent down on the floor, lent his elbows on a small chair and held his head in his hands without looking at us, without moving at all, and he did not give the least sign of impatience.

I thought: "my father who is so strong, who runs the home, who knows how to drive oxen, who does not bow before the mayor... My father in front of God becomes a child again. How much he changes his expression when he begins to talk to God. God must be very big if my father bends down in front of Him. But He must also be good, if it is possible to talk to Him without changing one's clothes!"

In contrary fashion I never saw my mother bend down. In the evenings she was too tired to do that. She sat amongst us, holding the smallest of us in her arms. She looked at us but she did not say anything. She did not open her mouth even if the smallest children annoyed her, even if a storm raged over the house or the cat did some damage or other.

And thus it was that I thought to myself: "God must be very simple if it is possible to talk to Him while holding a child in one's arms and while wearing an apron. And He must also be a very important person if my mother does not care about the cat or the storm when she is talking to Him". The hands of my father and the lips of my mother taught me much more about God than the catechism'.[2]

St John Chrysostome exhorted parents to bring up children, to educate them, to make them become the athletes of Christ. Each and every one of us, he said, should be like the painter who works on his painting with care. We should do the same thing with our children.

At the same time he complained about things with the following phrases: 'Nobody thinks about their children, nobody speaks to them about virginity, nobody talks to them about moderation, nobody speaks to them about despising wealth and glory, nobody talks to them about the facts which Holy Scripture proclaims. So, if children do not have teachers from an early age what will become of them? Everybody does everything possible to educate their children in the arts, in letters, and in eloquence, but nobody is in the least concerned about the principal element – educating their souls'.

Children have the right to know God and it would be a deplorable fact if parents and educators were to hide Him from them.

a. The Influence of Parents and Educators in the Sphere of Religiosity

a.1. The Trust of the Child Towards his Educators

A child learns from his parents and educators how to face up to life, to think and reflect, to wonder at things, to grasp the richness of nature, and to be sensitive. He learns to belong to a group, to a family which stimulates and encourages him, which brings him up with a knowledge of social, religious and cultural values. In feeling that he is loved and listened to, a child enters into the family project with its own victories and failures; he acquires experience, assimilates values and responds to life beginning with the 'words' and above all the 'actions' which he perceives in relation, for example, to vital questions such as health, death, work, friendship, and social and religious commitment.

The family and schools are important places for a child in his early childhood; they are of determining influence in his formation, in the construction of a system of values, and in enabling him to grow up with sensitivity.

a.2. The Meaning of Things

A child begins to discover the meaning of things at the stage of his life which goes between five and eleven years of age. Parents and educators play a sensitive and irreplaceable role at this point. This is the moment of the moral development, internalisation, and personalisation of religious acts, of education in the faith.

Who has not heard, for example, at the end of this stage a kind of call to become a member of a religious order? And in a balanced family and school context which is alive at the level of values who has not seen born as a spontaneous event a vocational call?

This photograph that I am showing here is more real in a society which is called 'sacred' to which the childhoods of almost all those present here at this national meeting belonged, something different from the contemporary context in which the role of the family and schools is lacking strength as a point of reference.

Because all of this is presented to children in an immature form, there is a great insistence in pedagogic terms on parents and educators taking on the role of guiding children progressively until adulthood. This is a pathway of overall growth with regard to the physical, mental, social and religious aspects of the child. At the same time the presence of 'models' helps us to reach our goals. If these models are near to hand and alive – that is to say parents, educators and priests – then the embodiment of the model, although only provisional, helps the child to grow and to mature.

There can be no doubt that a religious education helps a child to grow. This is because such an education places him face to face with central problems, life problems; it forces him to address them, to assess them...

b. How Should this be Done?

The answers here are certainly of a varied kind. I will confine myself here to the principles which are valid for all people.

b.1. Words Illuminate

Words reveal, explain, say you are right, and say why. It is important for words to preach the subject of God to children in a joyous way, to say how much God loves us, how much we can draw near to Him; it is important for them to be words which speak about friendship with God, words which generate a wish for God, a wish to search for Him, to want Him, to love Him, and also to preach Him.

This preaching does not belong to adults alone; children, too, can engage in it. The Day of Missions and Childhood of this Jubilee Holy Year has had as its subject: 'children: missionaries of the third millennium'.

It was to this, to missionary childhood, that John Paul alluded when he said that 'it is a real network of human and spiritual solidarity between the children of the old and new continents'.

b.2. Examples and Actions Attract

'Contemporary man listens more willingly to witnesses than to teachers or if he listens to teachers he does so because they are witnesses' (*EN* 41).

Examples of life are more effective than words. Although this is valid for all people it is especially true in the case of children. Children need models to imitate; this is to be seen in sport, films, songs... They want to identify with figures from these worlds, they put them in their hearts, in their lips, and put photographs of them in a frame which then look over a part of their bedrooms. Children see these models from near to hand and identify with them, they even imitate their gestures, use their words, and even dress like them.

His Holiness Pope Paul VI underlined the importance of example when, in relation to prayer, he posed the following question to mothers: 'Mothers, do you teach your children prayers the Christian way? Do you make them used when they are sick to thinking about the suffering Christ, to calling on Mary and the saints for help? Your example is a lesson of life, it is worth a year of worship... In this way you bring peace into your families... in this way you build'.[3]

Children need to learn the things of God; let us tell children about them with words; let us accompany them with examples.

'Divine things slumber in the depths of children and it is the duty of the educator to awaken them' (Adrienne Necker).

Not all moments and circumstances are the same. The educator must be discerning so as to know how to speak during these moments and to accompany them – fostering, illuminating; transmitting energy, courage, serenity, greatness, goodness, and love – the attributes of God which are manifested in nature and in a fundamental way in creatures. The truth that is God is said, stewarded, and handed on.

b.3. The Witness of Holy Children

The holy innocents. They gave their own lives in Bethlehem, in the place where the child Jesus was born, young children who were only two years old. They professed belief in the child Jesus not with their tongues but with their blood. The Latin poet Prudentius said of them: 'play, innocent ones, under the altar, with the crown and the palm leaves'. Their day is celebrated on 28 December.

Ines the pure, the martyr who was thirteen years old. 'How many snares her persecutor used to seduce her!' declared St. Ambrogius. Her day is celebrated on 21 January. *Lucia*, a radiant name, a martyr during the persecution of Diocletian, who 'struggled until death itself for the law of Christ'. Her day is celebrated on 5 February.

Cecilia, on 22 November, martyr of the faith.

Agatha 'the good', who met martyrdom during the persecution of Decius in 251. Her day is celebrated on 5 February.

Justus and Pastor, respectively seven and nine years old, who met with martyrdom during the persecution of Diocletian on 6 August 304.

Maria Goretti died a martyr at the age of twelve on 6 July 1902. She was canonised by His Holiness Pope Pius XII on 24 June 1950.

Francisco and Giacinta, the seers and visionaries of Fatima. Francisco died at the age of twelve; Giacinta at the age of nine. They were both beatified by His Holiness John Paul II on 13 May 2000.

The list could be extended if we take into account our children's hospitals, if we add the families who live their Christian lives in a coherent way, giving an example and bringing up their children in the faith. I would like to give you two examples.

Alexia González Barrós, who was fourteen years old and took the real road of holiness beginning with pain. She died in the university clinic of Pamplona on 5 December 1985. Her beatification is now being subjected to study.

Antonietta Meo (Mennolina). She was born in Rome in 1930 and died on 3 July 1937 when she had just reached the age of seven. She left us a diary containing one hundred and fifty letters addressed to Jesus, to the Holy Virgin, and to the Trinity. Scholars talk about this case with amazement because they see in these writings of this child a most beautiful theological system which at the same time reveals a life of intimate union with God. A life of holiness written up also through suffering. The process of her beatification is currently underway and there are those who speak about her being a new Doctor of the Church. After St. Teresa of Lisieux, a Doctor of the Church at the age of twenty-four, will we have another Doctor of the Church who reached that position at the age of seven?

I have wanted to draw attention to these figures to bring out and to demonstrate the fact that holiness is also present in children.

At the time of the beatification of Francisco and Giacinta, the Conference of Portuguese Bishops published a pastoral Nota ('Note') in which the recently beatified children were held up as being examples to follow 'because of the strength of their charity and their other evangelical virtues'. 'The child shepherds', continued this 'Note', 'remind us that children, too, have a role to play in the Church and in society... and that holiness is a vocation of everybody and a characteristic aspect of the people of God' (*L'Osservatore Romano*, Spanish edition, 12 May 2000).

The homily given by the Pope during the beatification of Francisco and Giacinta drew attention to the spiritual side of the little shepherds of Fatima (cf. *Ecclesia*, 27 May 2000). It was precisely the Pope who during the celebration of the Jubilee of Children of 2 January 2000 exhorted young people with the following words: "In beginning with you, children and teenagers, this series of solemn Jubilee celebrations, the Church places you at the centre of the attention of believers. Receive the gift of the Jubilee and go back home transformed by the love of Jesus who has given you his friendship. Follow him with enthusiasm and help everybody to draw near to him with total trust. Jesus is the Holy Door which allows you to enter into the Kingdom of God' (*L'Osservatore Romano*, 3-4 January 2000).

4. The Sick Child

It is not easy to be face to face with a sick person. We do not how to do this, we feel uncomfortable, it is something which is difficult and arduous. All of us

have gone through this experience, and priests in particular feel uncomfortable – they carry difficult 'weapons' of support in order to feel safe when they find themselves face to face with a sick person. Health care staff and personnel have the technical supports but often these constitute a barrier which give them only authority, prestige... These are defensive weapons. All of us have experienced these or similar situations when we have been face to face with a sick person.

If this is true, it is also true that when the sick person is a child the problem gets even worse. This is the mystery of pain which has no age, has no place, and not even gender. To suffer at the beginning of one's life – why should this be? Why do children suffer and die, that is to say the innocent? This is the question which Camus poses, and it is also the question which we ask ourselves.

I myself was a chaplain in a children's hospital in Barcelona. It had four hundred beds, a large consulting section, a first aid department, and a maternity ward with fifty beds which was joined to the hospital.

You can well imagine the activity, the burden of pain and hope, the ability of the professionals, the hardship of the days, the struggle for life, and many children who began their lives suffering. Many mothers were attached to the cross, hoping for a 'resurrection', in success achieved by medicine, even in a miracle. And then there was the professional activity, which was extensive and elaborate, and very serious, and in addition there were all the human and ethical questions and issues which arose every day.

And in the midst of all this there was the pastoral team which accompanied, encouraged and supported, and celebrated weak and sick life, but which at the same time was life full of vitality and experience.

How many Holy Fridays, but how many Easter Sundays! How many memories!

I remember the worry and stress of a young couple caused by the illness of their own child who died at the age of three months. And how much time spent in the chapel between hope and desperation!

– And the mother of Jordi, with what love and hope she looked after her child!

– How many families hoped that we would visit them. 'We were expecting you', they often said to us.

– And that father, Paco, disappointed and desperate because his child was afflicted by spina biphida, who did not believe in anything, who said that he had lost his faith... We pushed him to move out of the darkness, from his sadness, and with the passing of the days we saw more light and calm in that house, in that couple with their child.

– And what should be said about Alicia, aged twelve, and Juan aged eight, or of Gemma aged nine, afflicted by leukemia, of José Manuel, aged six, and Maria, aged three?

– Miguel was a child aged seven who was ill with cancer; his was a desperate case. The child was crying, he was ill, he was suffering and with the awareness of an adult repeated with a certain frequency between his sighs and cries: "Mummy, kill me!". We spoke to his parents and tried to be close to them, to energise them, but we did not have further time for a longer conversation. Everything was interrupted. It was very difficult, there was so much anxiety!

– Here is the observation made by a parent: 'In my work I feel distant and removed and I do not trust my colleagues... I have always felt that there was a lot of bad in people but after so many days in hospital I discovered this human value in the health care staff, in the voluntary workers, in religious service. I am happy even though my son is still sick. The hospital was a surprise'.

– And another parent: 'We parents, drained of spirit and frightened by the incurable illness of our daughter, were consoled only by the words of the priest who accompanied us during the baptism and the death of our daughter'.

– 'Many thanks, Elvira, you really helped me a great deal'. These were the words of a mother which were spoken to the person who came to visit her after the burial of her baby daughter had taken place.

Allow me to tell you about the witness of a young girl aged eight who suffered as a result of an accident which also injured her cousin, and whom we visited in hospital quite often. After being dismissed, she came one day to hospital to pay us a visit and brought various things including a letter which read as follows: 'Dear St. John of God, my grandmother thanks you very much with this bouquet of flowers for having looked after me and my cousin. Take care of all the children of this hospital. Help Yolanda and Gustavo, Rafa, and all the others, who are looked after as you looked after me. I would like you to give a lesson to the cooks who cook very badly and the children of the hospital do not like their

cooking. I am leaving you my crutches because I don't need them anymore because you cured me. I am leaving them to you so that other children who need them can use them, but I ask you to make sure that nobody has to use them this way because I believe that there is no need for people to die and to suffer because if these horrible things did not exist the whole world would live happily. I say this to you with all my love, Isabel Maria'.[4]

Scenes like this are many in number in a children's hospital, and certainly a priest will not have time to analyse as a psychologist does the experiences, states, thoughts and reactions of a child in relation to 'his illness' or 'his death'. We leave this analysis to the specialists and we think in overall terms of the daily life of the hospital with its large number of scenes and situations of parents and children who suffer. In many cases pastoral care must be directed more towards the first – with their pain and their worry – than towards their children, even those these last are very young. If the work of the hospital takes place in a real team, the pastoral service will be helped by other professionals, above all else psychologists, social workers, etc. It is enough to be in a team to 'gain advantage' from the skill of the professionals so that this can be of use to pastoral service.

I believe that pastoral service must play an important role in the 'child-parents' tandem and above all in the child-mother tandem in order to understand experiences, needs, and problems; to understand life and be present within it. For this reason, pastoral care and service should be largely directed towards a relationship of health in which trust is born, and beginning with which one can deal with the very many problems which come to the fore during moments of pain. The best pastoral care will be, therefore, a constant, discreet, non-invasive presence, a presence which is organised and co-ordinated in character and which lays stress on the salient points of the needs of people in a hospital. At the centre of things there will be the sick child and around him his parents and the health care staff and personnel.

This is not the place to discover what should be the approaches, forms, and styles of presence of the component members of pastoral service. These are things, rather, which should be studied and enriched through experience. I believe that knowing how 'to place oneself', that is to say knowing how to be somewhere, how to understand basic needs, how to have the grounds for being sure that you have a minimum of quality for the ministry of that place, and for the organisation of that service, are the inescapable baggage upon which all the component members of the pastoral service should be able to rely.

All these criteria will help in the daily construction of presence, dialogue, help, and sacramental and liturgical celebration. They will impart light to our words, and meaning to our actions. We experience the pleasure of sharing hopes and desperation, pain, anxiety, and joy at the achievement of success, of getting better. We will see new lives being born, lives resurrected amidst pain and death. It is enough not to be submerged by routine, by improvisation, and by not knowing what to do.

Today the Spirit is present, working. Today it continues to choose proclaimers of the news of life, of resurrection, of love, of joy, of celebration. To this call of the Spirit we must give enthusiastic and intelligent answers which are born from faith, full of the Spirit. The risks and the trials will be many in number but it is productive to call out with the strength of the Spirit: "I am here".

Evangelised to evangelise. We are convinced that what we proclaim is not our inheritance but what is entrusted to us by the Lord: "Go and spread the Gospel". We are convinced as well that the design of God is conditioned by the freedom of those men who reject and do not welcome the message.

We must now follow the example of Christ, of the Apostles and of many evangelisers who did not withdraw in the face of difficulties. Indeed, they armed themselves with courage, with enthusiasm, and with hope.

I exhort you for this reason not to allow yourselves to be defeated by 'illnesses of the body' which can check your evangelising enthusiasm – poor health, advanced age, tiredness... Or even less allow yourselves to be defeated by 'illnesses of the spirit': apathy, sadness, lack of enthusiasm, contradictions, and the infinite difficulties that are encountered...

Exercise yourselves, rather, in the gifts of the Spirit: 'love, joy, peace, patience, benevolence, goodness, faithfulness, moderation, self-control' (Gal 5:22), strength, hope; convinced that great works are the fruit of God but things which need our co-operation.

In this way will be born the new evangelisation: new in ardour, new in methods, and new in its expressions and manifestations.

These are the bases and the criteria around which we should organise pastoral service in a children's hospital which guarantees an evangelising presence. To this subject the next section of this paper will now be devoted.

5. The Service of Evangelisation in a Children's Hospital

a. To Evangelise – the Specific Mission of the Church

The Church exists to evangelise, to proclaim, and to communicate the Good News, as a continuator of the words and actions of Jesus (Mt 28; *EN* 13,14).

Evangelisation is the reason for the existence of the Church and if this is her specific mission then all her members must be strongly aware of their own responsibilities as regards the spreading of the Gospel.

a.1. Awareness of this Mission

To the Church as a community of believers, through the apostolic mandate, is entrusted 'caring for the sick'. This care for the sick is inseparable from 'evangelisation'.

The tradition itself of the Church, through her Magisterium, teaches us:

– that service to the sick is an integral part of her mission (*Dolentium Hominum*, 1);

– that the Church seeks encounter with man in a particular way through the path of suffering: 'man is the way for the Church' (*Salvifici Doloris*,3);

– that caring for the sick is a *diaconia* of local Churches and the universal Church. This ministry does not confine itself to her faithful alone but, out of loyalty to the Gospel, is open – and indeed must be open – to all those who suffer (Lc 10:25-37);

– that care for the sick involves approaching men in their spiritual-somatic unity (*DH*, 2);

– that it is thus mandatory upon the Christian community to help a sick person to free himself from everything that hinders suffering from being for him and for other people 'a force for redemption' (*SD*, 19);

– that care for the sick is an ecclesial 'diaconia' which expresses in a perfect way its essence as a 'universal sacrament of salvation' (*LG, 1).*

This care and concern of the Church for sick people, whose witness is not only broad and wide but also great in terms of quality, as is borne out by history; this care and concern, and I repeat the point, has been *emphasised by the Magisterium over recent years*. His Holiness Pius XII illuminated medical science with innumerable speeches of great relevance to the present moment. *Vatican Council II*, in addition to its message to sick people, urged both bishops and priests to have the greatest care and concern for 'the sick and the dying, visiting them and comforting them in the Lord' (*PO*, 6, 8; *LG*, 38). *Canon law* itself (can. 529 para. 1) reminds parish priests of their duty to help the sick and dying and reminds them that they should do so with generous charity.

Lastly, the two documents by the present Pope, John Paul II, *Salvific Doloris* and *Dolentium Hominum*, the first on the Christian meaning of suffering and the second a Motu Proprio which established the Pontifical Council for Health Pastoral Care, set in motion a new movement for pastoral care for sick people.

This pastoral care and concern was referred to in the same way by the Pope in his two apostolic exhortations, *Christifideles Laici*, sections 53 and 54, and *Vita Consecrata*, sections 82 and 83.

In the same way the pastoral care and concern of the Church towards sick people in to be found in the whole of the Magisterium of the present Pope, both in his numerous speeches at meetings with sick people and professionals of medicine,[5] and in documents of great important and relevance – canonic legislation, the new Catechism, encyclical letters, and apostolic exhortations. In all of these we find passages which directly or indirectly refer to the field of health and health care and which we have collected together and commented upon in the journal of our Pontifical Council, *Dolentium Hominun*. I here present them as follows:

Pastoral care in health in the documents of the Church:

Works written in the journal of the Pontifical Council for Health Pastoral Care, *Dolentium Hominum*:

Taking care of sick people according to canonic legislation (*DH 11*, pp. 5-8).

The Church and sick people in the new Catechism of the Catholic Church (*DH* 23, pp. 44-7).

Encyclical letters and apostolic exhortations:

– *Spiritum Vivificantem* (*DH* 5, pp. 18-20).
– *Christifideles Laici* (*DH* 12, pp. 8-10).
– *Redemptoris Missio* (*DH* 17, pp. 7-9).
– *Centesimus Annus* (*DH* 17, pp. 10-12).
– *Pastores Dabo Vobis* (DH 21, pp. 8-10).
– *Evangelium Vitae* (*DH* 29, pp. 4-14).
– *Vita Consecrata* (*DH* 32, pp. 7-10).
– *Una Speranza Nuova per il Libano* (*DH* 36, pp. 10-11).
– *Ecclesia in America* (*DH* 41, pp. 6-8).
– *Fides et Ratio* (*DH* 41, pp. 9-16).

a.2. An Evangelisation which is new in Ardour, Methods and Expression

Pope John Paul II in his encyclical letter *Veritatis Splendor* (6 August 1993) referred to this approach to the 'new evangelisation' launched ten years ago in a speech to the bishops of the CELAM (9 May 1983). The Encyclical has the following lines in section 106: 'Evangelization is the most powerful and stirring challenge which the Church has been called to face from her very beginning. Indeed, this challenge is posed not so much by the social and cultural milieux which she encounters in the course of history as by the mandate of the Risen Christ, who defines the very reason for the Church's existence "Go into the world and preach the Gospel to the whole creation" (Mk 16:15). At least for many peoples, however, the present time is instead marked by a formidable challenge to undertake a "new evangelization", a proclamation on the Gospel which is always new and always the bearer of new things, an evanglization which must be "new in its ardour, methods and expression"'.

Five years after his speech to the CELAM in Salto in Uruguay, the Holy Father explained the meaning of those sentences and said that evangelisation would be new in its *ardour* if – according to the extent to which it would be implemented – it increasingly strengthened union with Christ, the first evangeliser; it would be new in its *methods* if every member of the Church became a protagonist of the spreading of the message of Christ; for this evangelisation to be new in its *expression* as well people would have to have their ears wide open to what the Lord could suggest at any moment.

Every evangelising action must always begin with an action from within. That is to say the evangeliser must first evangelise himself or herself, undergo the experience of the encounter with Jesus the saviour (*EN*, 24) because evangelisation is above all the communication of an experience. This is not a professional activity connected with ideological propaganda, nor a philanthropic service. It is, above all else, a witness of life. In order to transmit the doctrine

in a convincing way witnesses are required.

We must avoid apostolic inertia; we must go beyond past schemata and repetitive rhythms. All of these cannot meet people's needs. It is not possible to evangelise with inertia. 'We must always escape the situation of a Church which has lost her first love, which tolerates idolatry, which has given way to compromise; we must always avoid the torpor of a Church which is asleep or which lives in a lukewarm way in mediocrity. This must be done so that we can be a *poor Church, a Church which listens to the Holy Spirit*. The transformation of the human so as to make him divine – this requires a *metanoia*, a radical change. Such as that progressive and then decisive change of the disciples of Emmaus: converted by the word and by the alive presence of Christ, they proceeded to change the direction they were taking'.[6]

Pope John Paul II faces up to this difficulty. Section 36 of *Redemptoris Missio*, which refers to difficulties within the Church, is of relevance here: '*internal difficulties* within the people of God are not absent, indeed these are the most painful. My predecessor Paul VI pointed out in the first instance 'the lack of fervour, even more serious because it is born from within. It is expressed in tiredness, in disappointment and above all in a lack of joy and hope' (*EN*, 80). Past and present divisions amongst Christians are also great obstacles in the path of the missionary work and commitment of the Church (*AG*, 6), deChristianisation in Christian countries, the decline in the vocations to the apostolate, and the counter-witness of the faithful and of Christian communities who do not follow the model of Christ in their lives. But one of the most serious reasons for the scarce interest in the missionary task is the indifferentist mentality, which is often rooted in an unsound theological vision and marked by a religious relativism which believes that 'one religion is worth the same as another'. We could add, as the same Supreme Pontiff himself observed, that there are also 'alibis which can impede people from engaging in evangelisation. The most insidious are certainly those for which attempts are made to find support in one or other teaching of the Council' (*EN*, 80).

The Pope seeks to encourage and stimulate people to overcome these difficulties: 'the internal and external difficulties must not make us pessimistic or inactive. What matters in this as in every other sector of the Christian life, is the trust that comes from faith, that is to say the certainty that we are not the protagonists of the mission – that role falls to Jesus Christ and his Spirit. We are merely helpers'.

In 2001 we will celebrate the ninth World Day of the Sick in Sydney, Australia. Its subject will be: 'the new evangelisation and the dignity of the man who suffers'.

In the message which the Pope has sent on the occasion of this World Day there is emphasis on the need to evangelise the health and health care sector, involving as it does great human experience.

In section three of his Message, the Pope tells us that hospitals are *sanctuaries* where people take part in the paschal mystery of Christ and that it is important that in these structures there should not be absent a clear and meaningful presence of believers who learn from Christ to be Good Samaritans.

Hospitals, health care centres and centres for elderly people are *favoured milieux* of the new evangelisation, says the Pope. It is important at the beginning of the new millennium that a renewed impetus is given to evangelisation in the health care world, the place indicated as that which should become a valuable laboratory of the civilisation of love, as the Pope says in this Message.

'If you are what you should be you will ignite the whole of the world' (John Paul II to young people in his homily at the end of the World Day of Youth, 20 August 2000).

These words are those of St.Catherine of Siena and the Pope employs them to send his message to young people. They are words of great topical relevance for pastoral care in health care centres where it is necessary to ignite an inner, spiritual apostolic fire, a fire which ignites our lives and our futures, and which ignites our vacillating and tired steps. To ignite means to place one's soul, one's life, one's love, one's service, and one's solidarity in the 'technical body', in the health care structures. Pastoral service must be the *soul* of the hospital, the soul of the health care structure. It must be a fire which *burns*, which imparts enthusiasm; a *light* which illuminates, a *joy* which alleviates pain, is *company* in loneliness, and *love* which heals and saves.

a.3. The Training of those Engaged in Pastoral Care in Health

Today, it will be difficult to achieve a new evangelisation in line with the criteria which have just been pointed out if those who engage in pastoral care in health do not have a basic pastoral training and if this training is not periodically up-dated. Vatican Council II placed a great deal of emphasis on this pastoral training and observed that all the other aspects of training must be directed towards pastoral goals and objectives (*OT*, 4). In the decree *Apostolica Actuositatem*, in sections 28 and 29, it is argued that pastoral training must be multifaceted and complete, suited to the various forms of the apostolate (sections 16-19, 31).

'The clear objective will be to achieve sufficient discernment of the pathways which the Spirit is pointing out to the Church within the changes of this society which is in a state of radical and accelerating transformation. One is dealing here with educating through a serious theology of pastoral action which embraces all fields: the moral, the social, and the spiritual; with training people through knowledge of a suitable of pastoral methodology and an upright set of criteria for action; of setting out the terms of the responsible solidarity of the Church in her action as regards human society; of educating people in basic work, in personal initiative, in a spirit of association, in team work, in openness to solidarity in ever broader forms' (cf. Joint assembly of bishops and priests, Spain, 'ponenza' VII).

The instruments to achieve this training are now many and varied in number. People are

trained beginning with experience, with integration into pastoral activity where good organisation, co-ordination, and assessment exists. This is a very important teaching chair. Training is achieved through attending the lessons of good mentors, courses, and weeks of reflection and thought. In order to achieve education and training in pastoral care in health with the academic qualifications of a degree and a doctorate in the theology of pastoral care in health, at the present time there exists only one centre in the world – the Camillianum in Rome, directed by the Camillian fathers. However, in many countries schools and centres for pastoral care in health are coming into existence, and this subject is being increasingly taught in seminaries and institutes which are engaged in teaching pastoral care.

I would like to emphasise the need for the health care worker to include in his life project a certain space for on-going training. We should not forget that the reading of books, journals etc. makes up a part of this kind of training, and that this acts to keep a person's mind lively and his ideals active and operational.

And one can pose the question: what is the result of all this? The answer is that it is always positive. A great deal of progress has been achieved. A great deal, however, has still to be achieved, but so far the results which have been obtained are a source of enrichment.

But we must be careful – we must not fall into the trap of stressing that which can be measured. Indeed, in pastoral care there are things which cannot be measured.

Pastoral action springs from a community of people and tends to create a community life of faith, charity, and participation. As a result:

1. The result of pastoral action cannot be measured in quantitative terms. It is not action which leads to a production of things.

2. The specific criteria of pastoral action require a process of elaboration which cannot be expressed solely with legal concepts.

3. The organisational approaches of public bodies, of trade unions, and of industry etc. cannot be applied in a unilateral way to pastoral action, even though all the advances of the human sciences in relation to group dynamics, work organisation, planning, and so forth must be certainly taken into consideration.

Pastoral action requires its own channels which provide greater breadth, greater effectiveness, and greater permanence. These may be called pastoral structures.

The structures of the Church are functional and instrumental when it comes to the carrying out of her mission. This is why they are necessary and contingent; this is why they are interchangeable.

The pastoral structures of the Church have a co-substantial contingent and instrumental character – they are never an end in themselves, they come from life, they must loyally serve life and be renewed with life (cf. the joint assembly of bishops and priests, Spain, 'ponenza' III, 01 and 02).

b. The Pastoral Project

This must involve the following headings: the people whom the project is directed towards, the pastoral team, and the programme itself.

b.1. The People whom the Project is Directed towards: Children's Hospitals

– This is a project which takes into consideration the place, *the hospital*, with its many technical, organisational, economic, social and ethical aspects.

– This is a *children's* hospital, and therefore there must be a knowledge of the realities of children, their experiences, their needs, and the reactions which are required when there is a situation of illness.

– To also see in a particular way the family context to understand the contact and the role that the parents and above all else the mothers have.

– Knowledge of the health care staff and personnel – their ties, motivations, values and needs.

– The dynamics and daily life of the hospital and in particular a knowledge of the average stay of the children in the hospital. Today this stay is very short and conditions 'solid and permanent' projects. Plans must be engaged in with a new mentality in relation to so-called 'urgent' pastoral action as regards a short stay and when there are conditions of a long stay in the hospital.

b.2. The Pastoral Team

It is true that in many cases there will only be one person linked to, and responsible for, the pastoral care provided in the centre. However, in this case as well this person must summon to help him 'voluntary workers' who have specific functions involving visits, the administration of Holy Communion, and so forth.

In many other cases there is a real team made up of a priest or priests, female members of religious orders, and members of the laity. All of these figures must have a good knowledge of the hospital context and environment, be 'ready' to carry out pastoral action in this sector, and

be suited to their tasks. The important thing in pastoral action are the people involved, that is to say its agents. Indeed, a person cannot give what he does not possess.

Pastoral care is worth what the pastor is worth; evangelisation is worth what the evangeliser is worth; and an apostolate is worth what the apostle is worth. These figures are not 'functionaries' but rather witnesses who enlighten, stimulate, co-ordinate, supply, and transmit hope, experience, and life.

It is important to promote the word in a team, to create a team, to foster it, and to ensure that it achieves and obtains knowledge. Each and every team, each and every group, is always a dynamic reality and has a process of maturation similar to that possessed by a person who always passes through the same stages of life, that is to say, childhood, adolescence, maturity, and adulthood.

At the beginning of the training of the pastoral team the following factors must be taken into consideration:

– patience (life does not develop in an instant):

– capacity for enthusiasm and hope;

– a certain amount of technical skills (because good will is not enough);

– material and mental time to be devoted to the members of the team;

– a good choice of co-ordinator to ensure that during the first stage of training of the group there are not any people who create difficulties.

If the guiding spirit and the inspiration of the pastoral team are factors of change, of transformation, then the group can achieve this transformation more easily. It is easier to change a person who is part of a group than a person who is isolated. A change which is achieved within a team generally lasts longer. We also know that decisions are more easily accepted if they are made within a group.

b.3. The Programme

'Pastoral programming is the study, the drawing up, and the deciding on a series of suitable and appropriate pastoral actions to ensure that the hospital moves from a given situation to one which is better'.

Once what programming is has been defined, the question poses itself: how should programming be engaged in? The answer is the following: through pastoral action which has goals and aims. This is because we believe that this is a largely educational process which responds in a better way to the end which is aimed at; because it obliges us to define choices in a better way and to be more serious as regards the tasks involved; because it progressively influences the renewal of those engaged in pastoral care; and because it compels us to engage in greater levels of fostering and co-ordination.

This organisation based upon aims and goals requires an analysis of the field of our work in terms the needs and possibilities which exist. Once the field of work is analysed, it is necessary to propose general objectives and specific and concrete actions.

The activities which support this programming must be studied well and have the ability to be carried into practice, connected with each other, in a way which takes into account the criterion of effectiveness. They must also be convergent. It is also necessary to take into consideration the principle of gradualness and the overall approach.

Lastly, in the programming we must take into consideration the present situation in which we find ourselves, what we want, and what it is possible to do.

For this reason, in this case the programme takes into account the children's hospital as a reality: it is necessary to consider its size, its dynamics, and its concrete situations. This is something which is fundamental. One is also dealing with a pastoral team which wants to operate as such, involving trained people with enthusiasm and the will to work; individuals with a programme which envisages concrete activities and the allocation and co-ordination of functions.

In this programming we should not forget two fundamental criteria – we must respect the creed professed by the patients, their family relatives, and the workers who are present. Pastoral service must be integrated into the work of care which is provided within the hospital. In no way should it be an island within the hospital.

A question then poses itself: what kind of pastoral activities should be engaged in within a children's hospital? After my comments on the pastoral team and the actual place where the pastoral service is engaged in, I will dwell upon certain areas of pastoral care.

1. The Staff of the Hospital

A constant relationship with the medical and nursing staff will strongly favour pastoral dynamics. The strong points of this relationship could be the following:

– taking advantage of the visits to the wards and other services;

– programming initiatives for the staff and personnel such as courses, conferences, etc.;

– integrating the pastoral service into the teaching dynamics of the hospital;

– taking advantage of holiday situations and social and family events...;

– co-operating with the inter-professional team in matters relating to the study of ethics, humanisation;

– the questions and issues which arise in professional practice.

2. With Children

The age, the situations and the length of stay in the hospital where the child is being treated must be taken into account. With all these elements taken into consideration, a pastoral presence is defined which is directed above all else towards:

– constant and planned visits;

– a 'catechistic' presence, especially in services for a child admitted to hospital for a long time, together with his school which beginning with the hospital follows the schooling of the child;

– a sacramental dimension. Here various factors are at work: the number of children in the hospital who are of an age to receive the sacraments, the religious practice of the children, the celebrations of the sacraments that are possible, how they should be practiced and when;

– the family. Everything that we do takes place through the family: visits, religious actions, celebrations, etc. All these realities should take into account the mediating role of the family as regards the child and at the same time the evangelising dimension that applies to the family.

3. The Team

The first dimension of the programme must also take into account the nature of the team – its needs and its responsibilities. The elements of the programme regarding the team could be the following:

– paying attention to the people who make up the pastoral team: their training, experiences, rhythms, integration, and activity;

– the strengthening of the different areas of the team: group dynamics, relations of mutual help, and the celebration of the faith;

– 'authorised and responsible' participation in certain dynamics and areas of thought and reflection of the hospital – ethical committees, welcoming and humanisation committees, teaching and instruction;

– the periodic assessment and evaluation of pastoral activities at various levels in line with a specific and sensitive chronogramme;

– taking care of contacts with the local parish, the pastoral area, and the diocese. This will help to provide ideas and communicate experience, in addition to receiving both of them as well.

Conclusion

After this long exposition, in which I have sought to identify and to shape a pastoral programme for children's hospitals, I would like to conclude by summarising what has been said in this paper by refering to the four following notions: *being*, *learning*, *saying*, and *doing*.

1. Being

To ensure good music what is really important is the musician, and not the musical instrument. Similarly, in pastoral care and work what is important is not the programmes but the pastors, what they are, and the life and the Spirit that they place in their programmes.

In pastoral care and work, if trust is not placed in the Spirit then failure is the result. The Holy Spirit is strength and light; the Holy Spirit is the protagonist of evangelisation. It is not our methods which produce effectiveness; it is the Holy Spirit which performs this office. Pastoral care and work are a question of witness more than methods. In pastoral work and care it is not our efforts which matter – strength lies not in doing but in being, being able to make the Risen Christ present, in ensuring that people discover Christ and can say: he is the Lord! (Jn 21).

What should we do for sick children? We must be witness, presence, silence, smiles, joy, hope, happiness, healing, and salvation. This is the dimension which the pastoral team must be able to infuse in all the pastoral care and action which takes place within the hospital.

2. Learning

From the child, from his or her family relatives, from the health care staff, we learn to enter into contact with others, to interact. We learn to rely upon people. They bring out how fragile we are and they teach us that it is beginning with our fragility, with our vulnerability, that we perform pastoral care and action. Only the 'wounded' person, the vulnerable person, can heal and save.

3. Saying

Before saying things we should listen and receive, create a context of nearness, of friendship which accompanies a person, which takes care of people.

We should tell, invite, offer and exhort a person to take up his bed and walk (Mk 2:1-12). We should impart enthusiasm, open up spaces, give life to 'paralysis', throw light on life so that the encounter takes place, so that the other person discovers his or her own faith without having to be convinced. Jesus in this is an example for us. Emmaus (Lk 24), Zaccharias (Lk 19), and Matthew (9: 9-13). We must be certain that we will discover the presence of God in our neighbour, as happened with Mary and Elisabeth (Lk 1: 39-47).

We tell, we sow, but we leave space to God; it is He who sows; let us allow time for growth – after all every seed needs time to grow (Mt 13).

4. Doing

Programming: we need to perceive needs, create, celebrate, participate, co-ordinate, and assess and evaluate. What should I do in a children's hospital? Provide solutions? Be paid back by God? Play at being a doctor or a nurse? What should we do, lastly, in the sphere of pastoral action and care?

Like the Samaritan (LK 10: 30-35), we should stop, draw near, and take care of. But remember: we are mediation, we are Samaritans who draw near to the wounded man, take care of him, place him on our mule, and take him to the inn... the Lord does the rest.

Decalogue for the Overall Care of the Sick Child

When I was a chaplain in the children's hospital of St. John of God in Barcelona, a decalogue was written which covered the scientific, human, deontological and religious aspects of what was intended, a sort of commitment on the part of the hospital to engage in and achieve overall care for the sick child. This decalogue is as follows:

1. Overall care for the child is our first and our principal duty.

2. We declare that we will subject our opinions and our love to scientific truth.

3. The practice of teaching in relation to the child will never be damaging for him or, nor will it offend his or her dignity.

4. In the field of paediatrics, the medical doctor and the nursing staff must act as delegates of the parents and for this reason love for the child must guide and shape their work of help and care.

5. Any doubt that arises in relation to the treatment of the child will be dealt with through consultation at the necessary level.

6. In relation to children, questions of race, religion, nationality, social origins, or friendship are of no influence whatsoever.

7. The incurable child, too, has the right to live, to be cared for, and to be loved.

8. We will give all the information that is necessary to those of our colleagues or the institutions who will carry on with the treatment of the child.

9. We will promote social paediatrics, the prevention of illness in, and accidents to, children through public campaigns and scientific meetings.

10. We declare ourselves united to, and partners of, the World Health Organisation and UNICEF.

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Notes

[1] C. ROCCHETTA, *Teologia della tenerezza* (EDB), pp. 145-146.

[2] P. PELLIGRINO, *Appunti di educazione religiosa* (Elle DiCi, Turin, 1994).

[3] *Ibid*., p. 12.

[4] J.L. REDRADO, 'El trabajo pastoral en un hospital infantil', see *Atti del Congresso*.

[5] J. JACIELKA, 'La pastorale degli ammalati nell'azione e nell'insegnamenti di Giovanni Paolo II (1978-1992)'. In this doctoral thesis the author brings together 310 meetings of the Pope with sick people and 230 meetings of the Pope with health care professionals, from 1978 to 1992, which took place in health care centres, parishes, and audiences granted to study-groups, conferences, etc.

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Philosophy, the Construction of a Profession

1. Introduction

The nursing profession is fundamental in the vast field of health and health care. Not to recognise this would be a calamity for the well being of *society, populations, families, and individuals*.

It is a certain fact that the nursing profession is very well known about in the field of health and health care, but it is my opinion that the nursing profession receives very little recognition.

In a world which is already very advanced as regards many sciences, experiences and knowledge, the nursing profession is easily placed in the context of 'science, experience and knowledge'. It has undergone an increase in its responsibilities and it has identified them and faced up to the consequences. It has incorporated knowing how to be and how to be spatially into its knowing about how to do things. Today, this profession has been placed on the level of a science and for this reason involves and requires empirical contents and epistemological elements. (I mean by epistemology the doctrine of the foundations and methods of scientific knowledge).

With its move to the university level, the profession has been enriched not only, and a great deal, in its own tasks and activities, but also with regard to other elements which come from medical doctors, pharmacists etc. Furthermore, it is enriching its own 'curriculum' through contents based upon principles relating to statistics, informatics, physics, management, psychology, sociology, law and other branches of knowledge such as philosophy, anthropology, human relationships and aid, its own history, the history of health and health care, etc.

Some people, but they are increasingly few in number, argue that a higher level of knowledge is not necessary. They ignore the fact that *looking after people*, which is the specific activity of nurses, is something which is very serious and involves much more responsibility than looking after machines, computers or numbers. It means taking care of a human being in his psychosomatic and socio-anthropological unity. This is something which is serious!

This profession does not belong to the field of treatment, which is the specific field of the medical doctor, but rather complements and enriches the service of care and looking after people. It is all a question of knowing how to plan – a science which today is an important part of the academic nursing curriculum. This profession needs to obtain all the relevant academic qualifications, and society needs competent, balanced, and responsible male and female nurses who are able to want and to obtain teamwork.

2. The Principles and Goals of the Nursing Profession

The nursing profession, in its long trajectory, has not been inclined to ask itself, or has only just begun to ask itself, the following questions:

– What is it (what am I)?
– What do I want to say?
– What am I seeking?
– What am I doing?
– What must I do and how must I do it?
– What does society expect of me or what does it entrust me with?

Upon what bases must it be based so that it proves:

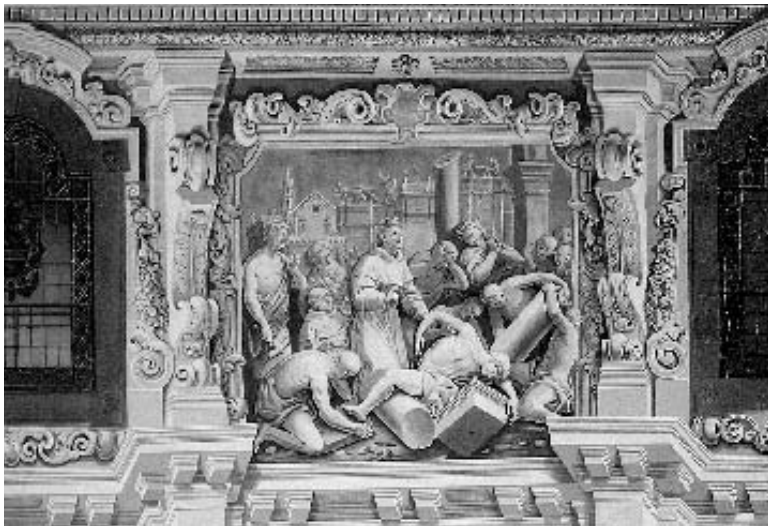
– advantageous;
– fruitful;
– attractive;
– acceptable?

Now that the nursing profession has reached a university level, and when we now ask that jointly with us a university law is drafted and passed regarding the acquisition of all the relevant academic qualifications, it is logical that we begin to give signs of greater professional maturity, that we know and want to ask ourselves aware questions, and that we seek to obtain satisfactory results. That we know how to distinguish what we should do and that this is adapted to what is requested by society. We could form a kind of axiom: *our profession must adapt itself to what society asks of us or may require of us*. We speak here about society and not about the ideas of an interest within society.

The nursing profession, ignorant or forgetful of its principals and its ends, must construct or reconstruct its idiosyncratic self, that is to say its

character, its individuality, its particular nature, its way of being, of locating itself, and of doing and acting. This means that the nursing profession must construct its own sphere of reference for contemporary times, for the geo-political or geo-social space in which we are journeying, in which we move, or in which we find ourselves.

The doctrinal and operational nursing 'corpus' comes from the most meaningful and ancestral aspect of the consciousness of mankind.[1] At the moment that the first feeling of pain, affliction, and weakness appeared on the earth within human beings, the nursing profession also made its appearance, always ready to place a hand on the forehead of our neighbour, on the forehead of the person who is nearest to us. This placing of hands on people has always been accompanied, indeed intrinsically joined by, words of consolation, by words which treat and take care of.



The placing of hands on the forehead, the laying of hands on pain, is exactly the title of one of my published works on our profession[2] and it is at the centre of the picture which appears on a Greek vase from the fourth century BC. Lain Entralgo analyses therapeutic speech, in its relationship to illness and disease, basing himself upon Homer, Hippocrates, Plato, and Aristotle.

Beginning with Homer, he defines therapeutic speech in the following way: it is imploring, magical, psychological or natural in character. And he goes on to observe: imploring speech is prayer; magical speech is empirical care and treatment, healing; psychological speech is speaking pleasantly and evocatively.[3]

For all these reasons we can observe that the nursing profession is the profession which uses *praxis* and *logo* in treatment or care for sick people. Basing itself on the philosophy of E. Kant, it revolves around three principles, which are as follows:

– critique of pure reason;
– critique of practical reason;
– critique of judgement.[2]

In this paper I will not dwell upon practical reason, the principal part of all professional activity. The result would be a very complex outcome, albeit fundamental in nature. Pure reason and the reason of judgement, of aesthetics, is what will be considered most fully in this paper. It is what we know as our philosophy.

The nursing profession of the nineteenth century and the first part of the twentieth century was largely and almost totally concerned with operational and practical concepts. At that time an executive hand of medical indications or orders, at the very outset such was not the case. Today the university nursing profession obliges us to inquire into philosophy, otherwise it would not be a university career. This philosophical approach to the profession may be summed up along a wide spectrum:

Philosophy, philosophical principles;
anthropology;
semiology;
culture;
quality;
ethics;
history...

These are principles which do not allow space for controversy, and they require debate, discussion, the contrast and interaction of constructive, strong, realistic, and where this is possible, positive, opinions. They are our 'logo' and our 'practice'.

3. The Nursing Philosophy

Every profession which sees itself as being a university profession must *demonstrate* that it possesses, and bases itself upon, philosophical foundations. Philosophy is not only the beginning of every higher reflection; it also becomes the principal element of human activity and feelings. To engage in philosophy means to search for basic principles so as to locate foundations in something which is solid, in what is most solid and meaningful in action and abstraction, in professional and also human care.

'It is vulgarly believed that science lacks philosophical problems and that it is nothing else but a machine with which to search for facts'. 'Philosophy allows an embrace of all the aspects which can present themselves in the examination of science – both the logical and the gnoseological, and maybe even the ontological'. (Gnoseology – the theory of knowledge. At times synonymous with epistemology. Ontology – the part of metaphysics which deals with being in general and its transcendental properties). 'It is necessary to distinguish the metaphysical problems of scientists, but one should not invent an abyss which separates them. Perhaps there is no scientific problem which does not raise philosophical problems, and no philosophical problem which can be addressed with hope of success if a scientific approach is not adopted'.[4]

When we speak or address questions of philosophy begin-

ning with the nursing profession there are many people who see the subject as something which does not concern us, who believe that *life is reality, not philosophy*.

Life, they say, or do we say?, is facts, not words. It is reality, not fantasies; it is results... something that is tangible!

For some, perhaps for many, philosophy is or seems to be a complicated subject, dealt with well or dealt with badly, which is imprecise, and at times pedantic. However, philosophy is a question of approach and also of aptitude. Because if it is true that philosophy does not provide many practical instruments, many technical discoveries, many empirical certainties, and special truths of science, it is nonetheless also the case that it searches for universal principles, vital and human logic, the concepts of common sense, of general learning, of history, of law, of ethics, of ontology...

Thanks to the fathers of classical philosophy we know that through philosophy, metaphysics, and wisdom, one comes to *goodness*. Goodness in Greek philosophy is identified with knowledge. Philosophy and goodness require theory and practice. For this reason, self-denial, lovability, the virtues: capacity, effectiveness, aesthetics, ethics... fertility are also called for. It is certain that the nursing profession through philosophy achieves fertility, abundance, riches, that is to say, as indicated at the beginning of this section, it comes to goodness.[2]

4. The Nursing Anthropology

Through philosophy one comes to anthropology and psychology. We can well consider Plato and Aristotle as the fathers of this branch of learning, at the least until near the end of the seventeenth century. The anthropologists of modernity came after that time.

The anthropology that we should consider beginning with the nursing profession and to which we should adapt ourselves is the anthropology which brings forms of knowledge which are most suitable to our realities and are based upon the human sciences. The branch of anthropology which should most interest us is so-called *cultural anthropology*, although other authorities think that anthropology should be 'adopted in all its full multifacetedness'.[5]

Edward Burnett Taylor, the father of modern anthropology, defines this multifacetedness in anthropological thinking with the following summary: 'all that complex which includes knowledge, beliefs, art, morality, law, customs and any other capacity or habit acquired by man as a member of society'.[6] We agree with San Martin[5] when he says that in the 'sense that the philosophy of man, philosophical anthropology, is a theoretical, practical and epistemological discipline'. And I would add, it is a cultural hermeneutic (hermeneutics: the art of interpreting texts or contents) discipline which seeks to interpret universal discourse – communication, questioning and the understanding of the human being, openness to others, the relationship of help.

The anthropology of suffering must encourage us to apply all the means, all the resources, all our will, to a human being in a state of need. The sick human being in today's world is in conditions of precariousness which we should assume and sustain so that his life finds meaning.

In all this, the *anthropology of hope* is of determining importance.[7] 'The only thing which in my judgement really heals is unconditional love'.[8]

5. The Nursing Semiology

Semiotics is an essential part of classical Greek philosophy. This paper will concern itself with *pragmatic semiotics* connected with the subjects who use it, that is to say with professional nurses. We believe that the most important signs of the profession belong to the semantic field of care. *We will be known by the care that we provide*, could be the determining frame of reference.

Nurses as agents of humanisation, of health. Nurses who look after people in the context of health, and, as a result of the services rendered, keep them in health or retrieve them from their bad general state, sustaining them and strengthening them with regard to their optimistic and gratifying life-infused state.

Beginning with these contents, which socially and academically are recognised as something which our profession possesses, we can apply the meaning, the appellative or the sign of an agent, that is to say, in these cases, of a professional who does something for us. And this doing something, this professional positive sign, is good, pleasant and health-inducing.

Being agents, being people who do something, such nursing semiotics make us builders, creators, the masters of works. These are humanising works which produce health. Acts, signs, in practical terms, which for Aristotle took the form of actuality and power:

– *actuality*, a certain movement, a change towards necessary realities, a step towards principles, philosophy, techniques, models, positive and satisfying results;

– *power*, which is always something and which becomes transformed into something else. This something should be positive, good, gratifying, and pleasant.

This vision of nursing semiotics, this professional conception which actualises and powers, also humanises. And this, in our work as health care agents, helps us to be more loveable, benevolent, good and understanding, but without us abandoning the professional side of things, that which is scientific, technical and epistemological. And in these procedures of providing assistance and care, of planning care, of diagnosing and implementation or practical activity, are to be found (or otherwise) the signs of our professional operational seriousness.[9]

The state and the form, the meaningful aspect of our nursing profession, must be based upon, and indeed require of us, the following:

– *aptitudes*, centred around general and specific training, theoretical and practical training, and on-going training as a

new and essential instrument of work;

– *attitudes*, which require co-operation with the milieu in which we work, with the therapeutic team, initiative, interest, discipline, good human relations, and a readiness to promote and provide a relationship of balanced help. And in addition, work in a suitably balanced team.

6. Nursing Culture

A distinction should be made here between *subjective culture*, education, instruction, the academic 'curriculum', and *objective culture*, the set of works and achievements of people, of peoples, which are acquired social traditions, total lifestyles, established and recurrent ways of thinking, feeling and acting – ontology.

In nursing we believe that these two concepts are inescapably bound up. Even more we believe that each culture depends on the other. Because of the fact of being an academic profession, nursing becomes of determining importance as regards the subjective culture. This intensely enriches the provision of services. There is thereby a deeper knowledge of the principles, the contents, and the value that accompany, or which should accompany, each form of help and care given to those who are in need.

Without a subjective professional culture it is impossible to achieve the level which is required by work provided within an integrated team. We would obviously and shamefully sing out of tune. Therefore I believe in, and support, the need to intensify such culture through known and necessary on-going or permanent training. On-going and permanent training means adding emphasis, values, attraction, quality, and meaning to the supply and the provision of services, help, and the proper and unrefusable care of the profession.

The objective culture 'in its broad ethnographic (ethnography: the science whose object is the study and the description of races or peoples) meaning' is that complex which includes form of knowledge, beliefs, art, morality, law, customs and any other capacity or habit acquired by man as a member of society'.[6]

This frame of reference which has just been outlined must be a field of reflection and practice for our professional work. And this obliges us to know and to follow in our work the concepts of *inculturalisation*, the culture that one generation transmits to another, that peoples, regions etc, transmit to new generations. It is certainly the case that some people are modifying this *ethnocentrism* with their *cultural relativism*, but we have to deal with the problem with care, with respect, at times with admiration and always with prudence because with regard to these great themes universal models of conduct do not exist. However, we must also dedicate great attention to alternative points of view.

Both the objective and the subjective cultures must lead us, professionally speaking, to research, to innovation, to methodological creativity. We can say that the person who searches with faith, with hope, always finds treasure. Health is always research, always a great treasure. People who ask for service, help, and support, are, by definition, the great treasure of mankind.[2] When we come to those who are in need of care and treatment, nurses must aspire to provide them with happiness, 'a necessary impossibility'.[10]

7. Nursing Quality

To ask oneself questions, to subject oneself to self-debate, to work, to develop, to arrive at the attainment of a philosophy, to energise a practice of the *control of quality* in the health care world, in the field of the nursing profession, means at the least to seek something which is certainly utopian or highly difficult.

The nursing profession must offer quality, and evaluate and perceive the level of its quality. This is because everything that we do, if it does not receive a specific weight, that is to say a value suitable to its reality, will lack value, will not have the right appreciation. We know that quality is demonstrable. If these principles are not achieved quality is absent.

In each of the initiatives undertaken by us we must always seek to achieve quality. Society cannot allow itself incomplete products or activities, or results of a low quality, even though quality will always be subjective and not objective, subject to the interplay and balance of other elements, whether they are well ascertained necessities, rather unsuitable instruments, up-to-date knowledge, constant training, or otherwise.

At times we speak about quality, its measurement, and it seems that we are dealing with something that does not actually exist, that does not even belong to the category of ideals as expounded by Plato. It would be sad, I think, to have to say that health care professionals, male and female nurses, with regard to the quality of their work, are what Heraclitus described as: 'men who have not reached these logos which have always existed, whether before hearing about them or after hearing about them'.[11]

After dwelling upon the concept of quality, let us now turn our attention to what we mean in summarising terms by control. A control is an exploration of what has been proposed and what has been achieved. Control is bound up with verification, confirmation, corroboration, levels of probability and the correspondence between two previously laid down limits. In this way there emerges a paradigmatic, analogical, question. (Paradigm: the relationships which exist between two elements. Analogy: the relationship of likeness which exists between distinct things or elements).

The truth is born from an adequate examination of the fact in hand, of its quality, and the convenient application of a correct form of control. For the ancient Greeks, it may be observed, truth and justice were closely bound up with order and measure. Plato proclaimed himself a teacher and a defender of justice. His book 'The Republic', indeed, constitutes a constant argument in favour of justice.[12]

Quality and its control are bound up with aesthetics, ethics and meta-ethics. They are used to establish order and analysis in the lives and actions of individuals, of professional people. Aristotle not only founded or rebuilt ethics as a philosophical discipline but in addition established most of the questions and issues that would later command the attention of moral philosophers: the relationship between norms and what is good; the relationship between individual ethics and social ethics; the classification of the virtues; the examination of the relationship between the theoretical life and the practical life, and so forth.[13] Later in this paper I will study the question of ethics.

Aesthetics, justice, truth, good and quality, and its control, must raise many questions for our professionals because they touch upon the deepest part of the human being, on the deepest part of the human being who is in need of care, assistance, and help. To formulate and to ask oneself questions is of determining importance for individuals, for persons. Quality and control – what else are they and what do they seek to be if not doing things well, without committing mistakes, with justice, with truth, and with aesthetics? These and many others are the questions that we should ask ourselves. In this field I believe that we should impose upon ourselves a series of metaphysical reflections.[14]

8. Nursing Ethics

With respect to ethics we should well bear in mind the philosophy of E. Kant and in particular his thesis on *categorical imperatives*, that is to say necessary, universal and incontestable realities regarding ethical behaviour; and on *hypothetical imperatives* – technical and pragmatic realities which concern practical life. Summing up these Kantian imperatives, this same philosopher proclaimed: 'work in such a way as to always deal with humanity, both in your own person as in that of another person, as an end, and never use it as a means'. Kantian ethics tell us why we perform our duties and why we should perform them:

– freedom;
– immortality;
– the existence of God.

This pre-supposes formal ethics which tell us how we should behave: autonomy, the commitment of the same subjects; proceeding without interested motives, distant from every form of selfishness. Such ethics require a balanced

knowledge centred around the *recta ratio*. Reason, indeed, was something which obsessed Kant.

The Catechism of the Catholic Church observes that the morality of human acts depends on:

– the object chosen;
– the end which is sought for, the intention;
– the circumstances of the action.[15]

In this conjoining of *objects, intentions and circumstances* is to be found, or may be found, virtue, the balance which the ancient Greek philosophers (and in particular Aristotle) canonised. It is the intermediate term between what is good and what is not good, between what is correct and what is not correct. But, certainly, 'the morally good act presumes at the same time the goodness of the object, of the end, and of the circumstances'.

This can be said to correspond to the *retto operare* of the classical thinkers.

Professionals who look after sick people centre their own professional ethics, according to their respective professional codes of ethics, around the following points:

– prolonging life, saving human lives;
– humanising the circumstances of sick people who have a high risk of losing their lives;
– respecting the opinion of the dying person, who must take his own decisions regarding the end of his life and his way of dying, and this either on his own or through his family relatives or accredited or legal representatives.

All of this draws us near, and leads us, to knowing the deepest meaning of *thanatos*. And with this of *euthanasia*, its range, and even its responsibilities and transcendence. And we spontaneously ask, we ask ourselves: why do we educate in *eros* and not educate in *thanatos*? However, we should make certain distinctions regarding the styles, forms or meanings of this term:

– *active euthanasia*: the artificial bringing forward of the end of life;
– *passive euthanasia*: caring for a dying person without using artificial means which modify a death of quality;
– *orthoeuthanasia*: death at a given time;
– *cacoeuthanasia*: active euthanasia without taking into account the wishes of the sick person or his family relatives or his legal representatives;
– *dystanasia*: deformation of the process of death, a disproportionate use of resources to obtain an extension of a life

which has very low human quality.[16]

In this area concerned with ethics, the therapeutic team is of essential importance. In relation to these questions it is always necessary to act in agreement, to have united ideas, criteria, thoughts, programmes and techniques, objectives, resources, and analyses of results.

Professional secrecy has a great deal to do with ethics and vice versa. It is central to the *Hippocratic oath*. *Roman law* laid down that 'the rules must be respected and secrets must be kept'. Christian culture talks about the *sigillum*. In more modern times we have the *Charter of the Rights of the Sick Person* and the *Deontological Code of the Nursing Profession*. In Europe we work on the basis of interpretations of the following different approaches:

– *the French approach*: the secret must always be kept;

– *the English approach*: the secret must always be kept as long as it does not damage the common good, which is always of greater importance.

Informed consensus is another ethical subject that the nursing profession must today embrace with the highest rigour. It involves respect for people and the prevention of the legal problems which can arise if such informed consensus has not been given.[17]

9. The History of the Nursing Profession

History is the richest patrimony there is of peoples, of individuals, of institutions, and of professions. We could say that a profession without a history is not a profession: 'what history studies is not a dead past but a past which in a certain way still lives in the present'. 'The duty to respect the facts which the historian adheres to does not terminate with the obligation to verify their accuracy. He must strive to ensure that there are not absent from his framework any known facts or facts that could be so, and which are relevant in one way or another to the subject that concerns him or to the interpretation which is being proposed'. 'The important thing in history is the character or the behaviour of individuals who have a noble lineage'.[18]

The nursing profession has not always borne in mind the need to know its own history with empirical data and for this reason there are in our libraries more reported or handed-on written materials than authentic documents based on evidence. These are informative materials more than evidence-based documentation, material more of a universal character than concrete, precise and empirical issues and questions. And the universal is generalised, less precise, as might be the case in the work by M. Patricia Donahue.[19] This can also happen in the case of other authors who follow this path.[20]

In Spain, starting in the 1980s, historical monographs have been published, such as that by Francisco Ventoso or my own in 1984;[21] by Carmen Dominguez-Alcon in 1986[22] and by Juana Hernandex Conesa in 1995[23]. In 1995 the second edition of my work was also published.[24] One is dealing here with works which are rich and based on historical proof. I do not know if all countries can offer on the subject such equally rich documented studies. I think that in this field of the history of nursing, Spain has followed the best path, a path which can serve as a basis for other well documented historical inquiries into the Hispano-American nursing profession. Things, means and history do not come from nothing! Everything is inter-related! The history of the Hispanic profession offers us a long series of really enviable historical studies which are without doubt based upon sound scientific evidence.

With these data we can make the suggestions of Gaarder our own: 'I am doing everything possible to make you aware of your historical roots. Only in this way will you be a human being. Only in this way will you be more than a monkey dressed up in clothes. Only in this way will you avoid floating in the void'.[25]

To quote a contemporary Spanish author, 'in times of orphans, when so many scoundrels have an interest in our continuing to be orphans, the past is the only thing that saves us and provides us with serenity to oppose ourselves to such times. History is the memory of what we were'.[26]

This is what happened in our profession until recent times. That is to say we were or we seemed to be orphans. We did not have or we did not seem to have parents, brothers or sisters, or a place of reference. For this reason we went to other sources, to identify ourselves with brothers or sisters who did not belong to our people, to our blood, to our culture. The nursing schools, many of their lecturers, still drink at foreign springs while they have at home so many rich, abundant and cool springs. It is not a bad thing to see what other people do, but it is better to know and taste one's own things, above

all else if they are very good.

These are some of the causes behind my dwelling on figures of professional nursing of a high level and teaching such as (to avoid going back to the medieval period) the figure and the teaching of St. John of God (1539-1550)[24] or Andrés Fernandez (1625)[27] or José Bueno Gonzalez. The work of this last, which has been recently published, saw the light twenty-six years before the first work of Florence Nightingale, in relation to whom Bueno Gonzalez did not pale in terms of the contributions he made to the profession, nor was he of lesser importance. Indeed, quite the contrary.[28] The whole of this situation of our profession; the whole of this historical documentation, has been an example of constant neglect, ignorance which could have been overcome. We must always be professionals in the search for meaning!

10. Conclusion

To conclude means to finally end the analysis of the subject of concern. I recognise that this has been a rather theoretical exposition but I have sought to present it with empirical facts and supports. I will try, therefore, to draw certain practical conclusions:

1. To be aware of the fact that our profession must base itself on and demonstrate that it possesses principles and philosophical bases, in addition to empirical contents.

2. The anthropology which we should see as ours is its cultural branch, centred around knowledge, beliefs, morality, art, law and customs. Philosophical principles.

3. Nursing semiotics centre around care, services, and attention being given to sick people and people in need. They must be positive signs of our professional work: philosophy and practice.

4. Our profession must look deep into the contents that it provides to subjective and objective culture, in order to increase research, innovation, creativity, and the methodology of assistance and care.

5. Quality and its methods of control are necessary elements in ensuring the carrying out of our work with aesthetics and ethics. With philosophical principles.

6. Our professional patrimony is made up of our set of experiences and what has been learnt during the course of history.

7. Nursing schools, with their directive bodies and teaching staff, must know and teach history on the basis of general evidence and by going deeply into our realities. Only in this way will we be informed professionals and stop seeing ourselves as orphans. We should make our own history a field of methodological and empirical research.

8. With this paper 'I have simply tried to open windows; in our happy country windows were not opened on the first day of its history – be convinced!'[29]

Taking into account what I have presented and outlined in this paper, one can build and strengthen a profession: our nursing profession!

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Neurological Aspects of Death

Man has a genetically limited life-span. The average life-span is now calculated as being eighty years for a woman and seventy-six for a man. The maximum duration of longevity has not increased, even though the people who reach this age are increasing in numbers. It is obvious that with the passing of time a person ages, that is to say that there is a decline in his intellectual and physical capacities, even when that person is in a good state of health. On the other hand, there are illnesses, such as Parkinson's disease and Alzheimer's disease, which are without doubt bound up with age. It is has been calculated that if people were to reach the age of a hundred and ten, they would all be afflicted by Alzheimer's disease. Furthermore, man is exposed to illnesses and accidents – living involves a great risk – which can provoke great limitations, and naturally enough, death at any age.

Death, as a biological process, is common to man and animals. In man, however, it has a biographical aspect, a specifically human perspective. Differently from animals, man knows that he is to die and as a result, being face to face with his own death, he must adopt an approach and develop a form of conduct. Animals do not know that they will die; they cannot reflect about death. If they do foresee it, this is not the outcome of an individual fact but the result of an *instinctive* act of the whole species (the bull in the arena who hides behind the fence; the elephant cemeteries etc.). The more a being is human, the more he is aware of the fact that life has an end.

As happens in the case of great questions, it is difficult to define death. '"It comes when the spiritual principle which governs the unity of the individual is no longer able to exercise its functions on and in the organism and the elements of the latter, left to themselves, dissociate. Certainly, this destruction does not affect the entire human being. The Christian faith – and not it alone – affirms the continuance, beyond doubt, of the man's spiritual principle". Faith nourishes in the Christian the hope of "again finding his personal integrity transfigured and definitively possessed in Christ" (1 Cor 15:22)'.[1]

In other ages medical science saw in the ending of breathing or of the heart beat the moment of death. The theology and the pastoral action of the Catholic Church held to these conditions, for example in the administration of the sacraments. Later, with the progressive development of technology, the diagnosis of death changed and theology absorbed this, aware of the fact that it is up to medical science to determine the moment at which death takes place, as Pius XII pointed out.[2] This decision, obviously enough, is based not upon subjective criteria but upon a rigid verification of the criteria which have been established for this purpose. In October 1985 the Pontifical Academy of Sciences published a document on this subject in which it was affirmed that 'cerebral death is the real criterion of death'.[3] A subsequent document of this Pontifical Academy made clear that 'the total and irreversible loss of all the encephalic functions is the real medical criterion of death which is habitually accepted'.[4]

Medical Aspects: Irreversibility and Decomposition

Death has two determining characteristics: one is irreversibility – that it is not possible to return from death to life – and the other is the decomposition of the body which begins once the person has died. In some tissues of the body this takes place within a few minutes and then reaches over the space of a few months total disintegration, finally leaving only the bones.

In order to affirm the presence of death two conditions must be met:

a) Cardio-respiratory arrest

A cardio-respiratory arrest of over ten minutes in duration is sufficient to cause the irreversible loss of all the encephalic functions, and thus, in ordinary circumstances, proof to the effect that this arrest has taken place leads to the affirmation that the person is dead. However, with techniques of resuscitation one can in some cases reverse the situation (in general in the case of arrests which are identified at the moment at which they take place – sick people who are being carefully followed, neonatal asphyxia being amongst the most frequent examples).

Resuscitation and cardio-lung rehabilitation constitute the set of techniques which are employed to re-establish breathing and/or circulation when these have stopped because of a potentially reversible cause. The most frequent cause of cardiac arrest in adults is ventricular fibrillation (a kind of arrhythmia) within the context of an ischemic heart disease (angina or myocardial heart attack). Every year in the United States of America (where reliable statistics are available on this subject) about five hundred thousand people experience an episode of cardiac arrest. Only one hundred thousand of these cases are reversible but less than 3% (fifteen thousand people) respond to the techniques of resuscitation and then return to a productive life. The goal of resuscitation is first to substitute and then to re-establish spontaneous circulation in order to supply a suitable flow of blood to the heart and the brain. To this end a set of techniques and different methods are employed (the opening of the mouth, artificial ventilation, cardiac massage, electric defibrillation, the administration of vasoactive and/or anti-arrhythmic pharmacies, etc.) in order to try to avoid the cerebral damage produced by the absence of a suitable supply of oxygenated blood.

In normal circumstances, when a cardio-respiratory arrest

takes place in a patient in a terminal phase because of an illness which is an advanced state and thus necessarily leading to death, there is no point in attempting a cardiac resuscitation. In many cases, even though carried out and having available all the technical means to hand, such an action would not manage to make the heart beat again in an autonomous way. In other cases, even if one managed to effect the operation and to connect the patient to a respirator, cerebral circulatory arrest and a complete halting of the encephalic functions would have taken place, and for this reason a respirator would have been connected to a dead body. To avoid these two last situations which wound the dignity of people, it is the usual practice in many hospitals to indicate that if a person in a terminal condition dies then these kinds of techniques and methods are not practiced.

In other circumstances, such as traumas, heart attacks in healthy people, poisoning because of drugs and pharmacies, very small children and in particular accidents through being put under water, everything possible must be done to carry out cardio-lung resuscitation.

Once the heart beat has been recovered and breathing has been re-established (whether spontaneously or mechanically), the situation of neurological consequences in which the person finds himself can be very varied – complete recovery, intellectual and motorial limitations at various levels, serious cortical damage albeit with a functional effectiveness of the encephalic trunk which allows him to engage in autonomous breathing (the vegetative state and other similar clinical conditions), and cortical, sub-cortical and encephalic trunk damage with consequences at the level of consciousness as well as dependence on a respirator (coma states at all levels). At times death inevitably takes place after a certain period of time even if the person is connected to a respirator and the heart beat is maintained and the circulation of the various organs is sustained through the use of multiple pharmacies with peripheric effects. This is because all the encephalic functions have irreversibly ceased.

b) The Individual is Dead even though his Heart keeps Beating (the neurological criteria of death)

The heart is able to beat in an autonomous way even though it is completely detached from the rest of the body. This ability allows a person, even in a situation involving the complete absence of encephalic functioning, to be connected to a respirator and also enables the circulation of the other organs of the individual to be maintained. In this way, the organs can be kept in a state of good health and their removal for the purposes of transplantation can be carried out. In this kind of situation, the individual is dead even though his heart carries on beating.

The ascertaining of the irreversible loss of all the cerebral functions has to be carried out only in intensive care units, and in some exceptional cases in the operating room, because one of the conditions for death will already have come into existence – irreversible respiratory arrest which will have led the person to be connected to a respirator. To prove that the person meets the neurological criteria of death, all the medicines which can have a depressant effect on the person's nervous system have to be removed. In cases of poisoning the necessary time has to pass so that all the toxic substance disappears. In this process, first of all the absence of the cortical functions (the ability to perceive) and of the sub-cortical functions (the ability to react at a non-specific level and to pain) is ascertained. Then the person is ventilated with oxygen at 100% for twenty minutes. After this the respirator is turned off and oxygen is introduced at the level of six litres/m through an endrotracheol catheter, and after ten minutes a check is carried out into whether there is a respiratory function. After this test has been carried out, the respirator is reconnected.

Then an inquiry is made into the integration reflexes of the cerebral trunk to see if they are absent: the pupils of the eyes do not respond to light or to actions which provoke pain, there are no changes in the heart beat as a result of pain, ocular movements are not obtained through placing iced water in the ears, there is no cough reaction with the introduction of an instrument in the trachea, there is no change in the heart beat after the injection of atropine, and hypothermia is also looked for. If these circumstances, which indicate the total absence of cortical and sub-cortical responses, and of integrated reflexes of the encephalic talus, exist, a diagnosis of death can be made. The respirator is removed and in a short time, usually after a few minutes and rarely more than a half hour, the heart beat also stops.

The clinical data which allow the ascertaining of death in the circumstances which have just been cited, can be corroborated by various exploratory techniques, such as the use of the electroencephalograph to ascertain the absence of cerebral activity, and the use of the arterio-

graph and the ecodoppler which reveals the absence of blood flow to the brain. This latter phenomenon is another physiopathological fact specific to this situation.

Legal Requirements in Cases Involving the Transplantation of Organs

If it is envisaged that the person in relation to whom the neurological criteria of death have been demonstrated to exist is to be an organ donor, the law requires that death should be verified according to neurological criteria produced by the use of an electroencephalograph carried out by a specialist in neurology and then carried out again after six hours. Furthermore, at the moment of the use of the electroencephalograph the brain must be inactive. This is a precautionary legal measure which in absolute terms is not necessary from a medical point of view and which in practice can have the result that the organs cannot be used after the six-hour wait. For this reason, there are attempts to reduce this period of time or to replace the requirement of the EEG with the criterion of an absence of flow of blood as measured with an ecodoppler. In Spain there was a parliamentary bill in 1999 which provided for the removal of the need for the second EEG after six hours and the replacement of this requirement with the forms of proof already referred to.

The Controversy about the Criteria Employed for the Ascertaining of Death

The neurological criteria of death enjoy great consensus in the scientific community because they were set out by the 'Criteria of the Ad Hoc Harvard Committee' of 1968. There is still controversy about the maximum length of time for the maintenance of the heart beat because there have been some cases, especially of young people and adolescents, where a continuation of the heart beat for several months has been observed, something which without doubt was helped by the practice of continuing ventilation and alimentation. However, the criterion of irreversibility remains valid and for neurologists one is merely dealing here with what are unrepresentative episodes. What is hoped for and what takes place according to the experience acquired day after day in intensive care units after the neurological criteria of death have been verified, and with all the therapeutic opportunities which exist to maintain the functioning of the heart, is that life ceases after a short while. Hence the need to reduce the legal time limit regarding when it is possible to engage in the removal of organs for the purposes of transplantation.

Another matter for controversy is that there is a wish to put on the same level the very prolonged situation which ends up with a cardiac arrest and a prolonged vegetative state. Even accepting that in social terms the two solutions could involve an approach with certain analogies, in scientific terms one is dealing with situations which are not the same given that in the vegetative state the patient breathes in an autonomous way. One could also want to put it on the same level as situations of deep coma which are considered to be irreversible where it is opportune to support the breathing which the patient continues to engage in, albeit in a very precarious way, with assisted ventilation, because the patient would have a cardio-respiratory arrest if this aid was removed. In these cases the respirator can be removed if it is thought to be a disproportionate measure – the patient would die after a short period of time, but his organs could not be removed because a cardiac arrest would have already taken place.

A final reason for debate is provoked by the fact that the various tissues have a varying sensitivity to hypoxemia, with the result that the cells die in a staged way and the functioning of certain organs continues even when others have been irreversibly damaged. Death means the irreversibility of the overall biological functioning of the person as a unity, and a process of the disintegration of the tissues begins. These conditions arise once cerebral circulatory arrest has taken place, and only when this has taken place, One can say that death is a process from a clinical point of view. For example, the period which is considered terminal in a sick patient, or the hours which remain to a patient with an unchangeable condition of endocrinal hypertension with cranio-caudal herniation, or the death throes of a person, we rightly describe with the phrase: 'he is dying'. However, it would be erroneous to say that a person is not dead until all his cells have died. As Martinez Lage observes: 'death or the end of life do not need adjectives'.[5] Either a person is dead or he is not. The phrases 'clinical death ' or 'cerebral death' are not advisable. They can give rise to confusion about levels or types of death, which is reality is of one nature and unequivocal. It would be better to refer simply to 'death'. The neurological diagnosis of death must be (and in fact is) total as well as independent of any factor or circumstance relating to the dead person, the plans or beliefs of his family relatives, and the possible donation of his organs for the purposes of transplantation.

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Notes

[1] THE PONTIFICAL COUNCIL FOR PASTORAL ASSISTANCE TO HEALTH CARE WORKERS, *Charter for Health Care Workers* (Vatican City, 1995), n. 128.

[2] Allocution, 1957.

[3] 'Il prolongamento artificiale della vita e la determinazione esatta del momento della morte', in *L'Osservatore Romano*, 30 October 1985, p. 5.

[4] Cf. R.J. WHITE and I. CARRASCO DE PAULA; Angstwurm, *The Determination of Brain Death and its Relationship to Human Death* (Vatican City, 1992), pp. 207ss.

[5] *Diagnóstico de muerte. Criterios neurológicos*, Doc. Oficial de la Soc. Española de Neurologia, approvato dal V Congresso Nazionale, 12.IX.1982; cf. E. MARTINEZ VILA and M. MARTINEZ-LAE, 'Diagnóstico de la muerte. Criterios neurológicos', in J. HERREROS, R. ARCAS, R. AZANZA and P. ERRASTI, *Trasplante cardiaco* (Cinetifico-Médica, Barcelona, 1986), pp. 65-67.

Fears and Hopes in the Face of Death

The philosopher Plato used to impart the following lesson to his disciples: 'practice dying'. And the psychiatrist E. Kubler Ross has repeatedly observed: 'the person who has not really looked death in the face is a person who is not really free to live'.

Death is an appointment which awaits everyone – both those people who expect, and have made provisions for it, and those who have rejected it.

Day after day we build up our lives; day after day we experience death. These two dimensions of existence assert themselves constantly.

Although on the one hand Western society has achieved enormous progress in the sphere of medicine and in producing the illusion of health and well-being, on the other hand a regression can be observed in the ability of modern man to manage the event of death. In fundamental terms, fear has now achieved a position of dominance.

In the face of situations which involve mortality, society clothes itself in fear and these are clothes which many people wear all the seasons of the year.

This is not so much a fear which makes people human, thoughtful and inspired with solidarity, but a fear which paralyses, suffocates freedom, and takes space away from hope. It is a fear which means that some phrases (such as, for example, 'I am about to die') cannot be pronounced without encountering a reproach, that some subjects cannot be dealt with without the people who do so appearing pessimists or people who give up, and that some 'goodbyes' cannot be made without unmasking a truth which it has been decided to deny.

The dominance of fear involves as a consequence the abandoning of openness and creativity – the daughters of real love – and the provision of a welcome to anxiety and futility – the daughters of paternalism or selfishness.

The Roots of Fear: Cultural Conditioning

The burden of fear in the face of death has first of all cultural roots. People are the victims of a model of looking at death which makes them lack resources with which to manage this event in an open and mature way.

Daily demonstrations of this disturbance are on the one hand the tendency to employ – in the face of diagnoses which offer no hope – underhand methods, benevolent deception, or the so-called 'conspiracy of silence' in the mistaken belief of being able to protect one's loved ones from the truth, or on the other hand, the practice of drawing upon a certain kind of language so as to soften or reduce impact with pain.

Thus, for example, people speak about 'neoplasm', or an 'oncological problem' or a 'bad malady', because to say 'cancer' seems to be too cruel and disrespectful. Or people use phrases such as: ' he has gone', 'he has left us', 'he is no longer with us', 'he has gone away', 'he has fallen asleep for ever', because to say that 'he has died' seems to be too cold in tone and too final.

At times, even in front of people who insistently uphold their right to know the truth of their own condition, their family relatives, conditioned by fear, play to the last card the game of paternalism, which is nothing else but a false way of interpreting charity.

In this way dying people are deprived of the right to fulfil their own lives, to take leave of their own loved ones by giving expression to the thoughts and feelings that are within them and expressing their last wishes.

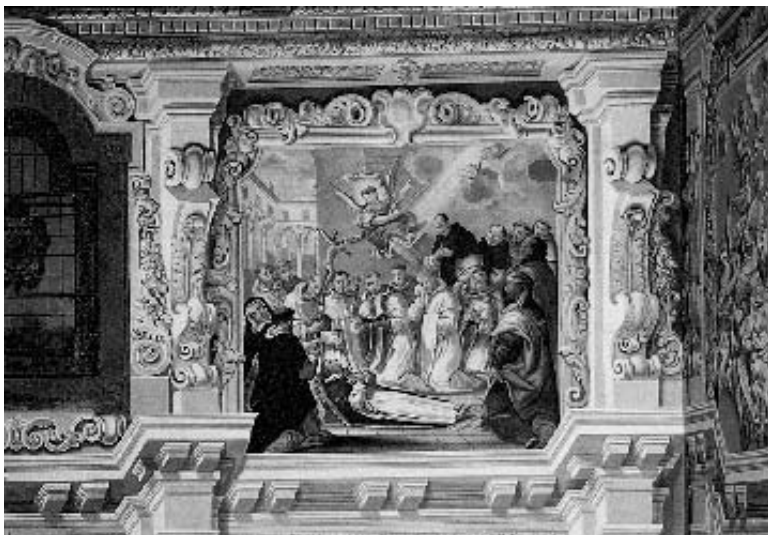
In this way the opportunity to be loved deeply in the most authentic way possible is taken away. We are deprived of the never to be repeated experience of preparing ourselves for the break by sharing smiles and

tears, memories and hopes, feelings and messages, without handing such things over to the grave or to later regret.

The model of communication which is learnt is handed down, and for this reason parents transmit to their children the inheritance of their unresolved fears. In this way, children are protected from pain – rather than visiting their dying grandfather in hospital they must remember what he was like when he was healthy; rather than preparing themselves for the funeral of a loved one they are invited by their aunt and uncle to the seaside for a few days.

It is not realised that in protecting them from pain one is protecting them from life by perpetuating in them the incapacity to face up to, and to address, the inevitable events of existence with realism and serenity.

Death can neither be taken away nor avoided. The challenge lies in facing up to it – both those who die and those who remain – by activating the inner resources which are present within each person.



In proportion to the extent to which people are educated to break the slavery of fear so as to begin a season of hope through a healthy facing up to reality, cultural models which are more constructive in character are created by which to manage dying and death.

The spread and diffusion of these models depends upon the embrace of a change of mentality which is facilitated by courses on the subject, by the reading of articles and books which generate new forms of sensitivity, by the suggesting of ways of dying which are different from those suggested by the mass media, and above all else by an experience at a family or professional level which is lived out in an innovative, human and humanising way.

The Various Faces of Fear

The conditioning effects and consequences of the cultural model in its various expressions (the removal, denial, institutionalisation and medicalisation of death) become translated into a personal experience when death knocks at the door of one's own door.

The threat to one's own safety and project-making unleashes a range of fears whose character conforms to the identity, experience, values and roles of the protagonists involved. Fear does not have only a name – it also has different faces and shades.

In paying special attention to the terminally ill, different fears can be identified, each one of which can be the central worry of the person. Of the most common fears the following may be cited:

– physical pain;
– the unknown;
– judgement (by God, by other people, by oneself);
– separation from one's loved ones;
– dependence on other people (one's family, the health care personnel and staff);
– feeling that one is a burden;
– disfigurement or physical decay;
– the loss of self-control (mental self-control or incontinence);
– the loss of dignity;
– loneliness;
– the feeling of uselessness (the loss of meaning or of the will to fight);
– the fear of being forgotten about (of not leaving any traces of one's passing);
– the fear of total elimination in death.

Of all these expressions of death, the fear of dying alone is that which is most frequently encountered.

Fear is the child of our humanity and springs from the experience of vulnerability, powerlessness and mortality. There are no magic formulas which can eliminate it. Some people calm fear with prayer and faith; others with breathing exercises and meditation; and yet others with an approach of sharing and acceptance.

It is often the case that giving voice to one's own fears means that they change and become a matter of placing oneself in the hands of, and trust in, that *Somebody* who said: 'do not be afraid, I will be with you for ever'.

In general, fear becomes cut down to size in proportion to the extent to which it is counterbalanced by the dynamism of hope.

The Different Faces of Hope

Man is instinctively led and impelled towards hope, and this is something which is most activated when one's health or life is in danger. Hope, like fear, is a Joseph's coat of many colours.

When faced with a grave infirmity or the drawing near of death, man perceives the horizon of his own experiences along the following three pathways:

a. Medical Hopes

In the majority of cases this is the favoured and special terrain where the destiny of one's own future comes to be played out.

The range of hopes linked to science and physical recovery include the following:

– trust in medical doctors and their knowledge and professional skill;

– the arrival of new drugs, medicines and forms of treatment;

– journeys of hope to specialist centres;

– alternative medicines.

This understandable but at times exaggerated and unrealistic concern with the healing of the body emphasises the preponderant role that the biological dimension has at the expense of an overall vision of health. For many people hope has only one name – that of physical healing.

b. Human Hopes

These are a favourable terrain for the building up of spaces of health; health understood in a broad sense and thus not limited merely to the biological sphere but inclusive, as well, of biographical health – something which embraces the whole of the emotional, social, cognitive and spiritual sphere of the person.

Human hopes when faced with death include:

– the need to communicate one's own thoughts and feelings to one's loved ones;

– the desire to live and to make small plans;

– the wish to share the archive of one's own memories, whether they are fully open or hidden away;

– to give voice to those of one's dreams and projects which have never been realised;

– the need to alleviate one's pain or loneliness;

– the wish to be able to die at home;

– the need to take care of those questions which are most urgent before dying;

– forgiveness or the receiving of forgiveness;

– saying goodbye to one's own loved ones.

The presence of good listeners who give space to the dying person, who adopt an approach of welcoming and humility, upholding and honouring the choices which have been taken, help the move onto the other side of the bar.

It is clear that human ability in this sphere is not something which can be improvised – it is an apprenticeship which requires an ability to live in a positive way with one's own humanity and powerlessness, a knowing how to leave to the other person the protagonism of his or her dying, and making oneself a discreet and near presence during the course of the final journey.

This is how Calrise, a teacher who died a few years ago in the United States of America, sought to prepare her husband for the separation:

Can I Leave?
Can I go away?
Don't you think that the moment has come?
I am ready to say goodbye to days full of pain,
and nights full of loneliness.

I have lived my life and I did my best.
Now, let me take this step
and allow me to free my spirit.

At the beginning I did not want to go away;
I struggled with all my strength.
But now there is something which attracts me
towards a light that gives me peace and warmth.

I want to leave! Really, I want to!
It is difficult for me to stay.

I will try to live to the best for one day more
to give you time to take care of me,
to share your love and your fears.
I know that you are sad and worried,
I can read it in your tears.

I promise you that I will not be distant from you:
with my spirit I will be near to you.
Wherever you are...
Thank you for having loved me,
you know how much I love you too!
This is why it is difficult to say FAREWELL
and separate myself from you.

Embrace me once again
and tell me that TODAY you will let me leave,
because you love me.

(Clarisse H., 1993).

c. Spiritual Hopes

The third horizon of hope extends beyond the biological and beyond the human to embrace the transcendent, that is to say that which gives meaning to life, to suffering, and to dying, that which goes beyond death.

The spiritual horizon includes first of all acceptance and reconciliation with one's own past, with its wounds, errors, sins, and missed opportunities.

The process of reconciliation can be facilitated by the sacrament of confession, by sharing one's experience of guilt or regret with someone, and by the silent dialogue of the dying person with God – He who reads in the secrecy of each and every heart.

Living out reconciliation means ensuring that remorse or inner torment brought about by errors which have been committed or plans that have never been realised do not come to prevail. It means, rather, enabling the compassion of God to direct one's path, living in peace with one's own limitations, and acquiring inner serenity.

Secondly, the spiritual horizon embraces the present and includes the ability to honour human dignity, even in the midst of physical trial and tribulation, which prostrates itself and is wounded in the face of the limits of human nature which make one experience the 'dark night' of the soul with a feeling of dismay and disorientation.

In the face of the knowledge that life is gradually coming to an end, one can ignite a new spirituality which has a positive evaluation of the small things of life, those things which are so often taken for granted, and draw upon the resources of prayer, of thought and reflection, of faith in God, of the comfort of the sacraments, so as to transform the wait into hope, and death into resurrection.

To live the present in a spiritual way means to find spaces of light in the darkness of dying, to pronounce and receive healing words and actions in relation to one's loved ones or those who are taking care of us.

The spiritual horizon is projected, lastly, into the future: it goes beyond the mortality and the finiteness of the flesh. It is based upon the belief that the destiny of man is a full encounter with God, it is to believe in continuing existence in a mysterious life beyond this one which awaits us, and where it will be possible to meet again one's loved ones and enjoy the fullness of life.

Accompanying dying people requires respect for the various creeds and religious, which are professed. Even where the person says that he or she does not believe in a life beyond this one it is important not to persist in trying to convince him or her otherwise but to help that person to revisit his or her past and to uphold the values, achievements and meanings which have marked out his or her personal history.

The Mystery to be Discovered

For all people, death is a destination and a mystery – an inevitable destiny and an inescapable mystery.

The fact that death places an end to human project-making produces in many people disturbance and disquiet. The objective is to ensure that fear does not come to prevail over love, over creativity, and over hope.

The cultural and personal challenge lies in receiving death as a part of one's life, in creating positive experiences and models as to how one can die, and in educating family relatives and health care workers to be instruments of comfort and nearness at the side of those who are dying.

Christian hope is not an alternative; it has a complementary role in relation to the other hopes. It is at the same time historical and transcendent. It is going on living the mystery which began with birth, something which is so well interpreted in the following parable:

The Two Twins[1]

While two twins were growing in their mother's womb they had a conversation with each other. They were full of joy and said: "Well, don't you think that the experience of life is incredible? Isn't it great to be here together".

Day after day they went on discovering their world. One day they became aware of the umbilical cord which connected them to their mother, and by which they were fed and nourished. They were surprised and said: "Just look how much our mother loves us: she is sharing her life with us".

In this way the weeks and months passed by and they suddenly realised how much they had grown.

"What does all this mean?", asked the first twin. "It means that in a little while we will no longer be in here", answered the second: "We can't remain inside here for ever, we will be born".

"I don't want to leave here at all", objected the first, "I want to stay here for ever and ever!" "Think about it", his twin brother answered him, "there are no other possibilities, and then perhaps there is another life out there, once we've got out of here".

"But that's not possible", argued the second, "without the umbilical cord you can't live! Moreover, many others have left the maternal womb before us but nobody has come back to tell us whether there is another life after birth. Believe me, once we are out of here everything comes to an end!"

Thus between one contention and another they spent their final days in the womb until the moment of birth arrived. When they came out into the light they opened their eyes and gave out a great cry.

What they saw far surpassed what they had ever thought they would see.

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Note

[1] Labensangste-Lebenstraume, en Kranteunrief (1999), 1, p. 3.

Testimony

The Servant of God,
Manuel Lozano Garrido:
Paralytic, Blind Man,
Journalist and Writer

The Hospital of the Holy Spirit
of Rome as an Example
of the Apostolate
of Compassion

The Department of Pastoral
Care at the Cardinal Tien
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Archdiocese of Philadelphia:
Protocol for Evaluating
the Catholic Health Care
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The Paulinian Approach
to Nursing Education:
A Response to the Church's
Call or Compassionate Caring

The Servant of God, Manuel Lozano Garrido: Paralytic, Blind Man, Journalist and Writer

On 5 November 1994, in the diocese of Jaén, the opening of the process for the canonisation of the Servant of God, Manuel Lozano Garrido, was celebrated. The solemn ceremony was presided over by the Bishop of Santo Reino, H.E. Msgr. Santiago Garcia Aracil.

On 20 February 1998, at the Congregation for the Causes of Saints, the decree on the validity of all the diocesan practical procedures in the matter was signed. The 'Positio' on the heroic virtues of this sick man was printed and submitted to the examination of the Consultors.

Who was Manuel Lozano Garrido?

Manuel Lozano Garrido was a member of the laity who was shaped in his views by being a member of the Youth Section of Catholic Action; he was an invalid, a blind man, a journalist and a writer. He was a simple man who experienced Christian joy, born from his deep faith, in a condition of pain which lasted for more than twenty-five years when he was completely immobile on a wheelchair.

His life of constant prayer has been handed down to us because it is captured in his nine books, examples of very high religious literature, and in hundreds of press articles in which he expounded the social doctrine of the Church or spoke about the small successes of his daily life which were obtained beginning with his Christian commitment.

'Lolo', as he was affectionately called, was also known for his deep devotion to the Eucharist and a tender Marian compassion.

His life was a constant apostolate amongst the incurably ill to whom he joined himself in a pious union, called 'Sinai', and to whom he offered his prayer and his own pain through the Catholic press. At the same time, his home and his own life became a lighthouse which shone light on, and apostolically guided, through the wise advice that he supplied, hundreds of young people and adults, who turned to him as a friend, a confidant, and an adviser.

Manuel was a member of the laity who lived out his life in love with the Church, for which he had a real passion and tried to serve in his apparent uselessness; he was a paradigm and an example of 'today for today', and had a *spiritual profile* which was simple and at the same time heroic.

The universal call to holiness and the role of a layman within the Church, emphasised by Vatican Council II – which this Servant of God followed with passion from his wheelchair – met with a deep echo in Lolo. During his years of adolescence and as a young man in Catholic Action he was already writing in his notes about his keenly-felt wish to follow Christ; and as a young member of the laity he risked his own life during war time and religious persecution because he openly professed his faith and his devotion to the Eucharist – this even led him to suffer imprisonment and to wish for martyrdom.

The simplicity of life of this boy, who in the fullness of youth became completely paralysed, made him live out in a natural and 'joyous' way the extraordinary circumstances in which he experienced his very long life in the condition of an incurably sick person.

What has just been observed is merely a compendium of his life. I would go beyond the confines of this paper if I commented on every one of the characteristic traits of this *spiritual profile* that I have just outlined. But the richness of the Christian life of this young man of Catholic Action, an invalid and yet a writer and an adviser of the young, has an aspect on which it is necessary to dwell in this paper, which will be published in the journal *Dolentium Hominum*, namely the apostolic dimension which the Servant of God, Manuel Lozano Garrido, gave to his illness.

1. Biographical Aspects

Manuel Lozano Garrido, Servant of God, was born in the industrial and mining town of Linares (Jaén, Spain) on 9 August 1920. He was a member of the Youth Section of Catholic Action from its foundation in that town in 1931, first as an activist and then as a person with posts of responsibility. At the age of twenty-three, while he was doing his military service, he was attacked by rheumatism which completely paralysed him and turned him into an invalid. In the last years of his life this illness also made him blind. He died in Linares on 3 November 1971.

His years of adolescence and youth coincided with those of the Spanish Civil War (1936-1939) when he was put in prison for a few months because of his faith. Before going to prison, like a twentieth-century version of the novice 'Tarcisius', he secretly distributed Holy Communion on behalf of Don Rafael Alvarez Lara, who was a parish priest of Linares and later Bishop of Guadiz and Mayorca.

After the Spanish Civil War he was a member of the Youth Section of Catholic Action when he forged his apostolic spirit and deepened his human and spiritual education, which he subsequently expressed to the full during his twenty-five years of being an invalid.

During these years (1939-1941) he pursued the career of a teacher and studied to become an expert in mining.

Once his condition as an invalid had been made official, his life took on a totally different direction – starting with his total immobility he became a journalist and a writer, an adviser to hundreds of young people and to all those who drew near to him.

His life, which was only apparently useless, became wonderfully productive and fruitful – when he could no longer write with his right hand he wrote with his left hand; and when he

lost his sight he recorded what he wanted to say on a tape recorder.

He published hundreds of article in the press on social, scientific, literary and above all else religious subjects and themes.

His strength came from an intense life of prayer, from a deep loyalty to the Eucharist, and from a tender Marian devotion, as we can see from his profound spiritual 'diaries' which make up parts of the nine books that he published.

When, as an already sick man, he was allowed to celebrate Holy Mass in his own home, he asked for his typewriter to be put under the altar so that in this way 'the Cross will become nailed to the keyboard and put its roots into it'.

He called on the Virgin, to whom he dedicated beautiful pages in his writings: 'Holy Mary of things without splendour; Queen of the Twin Hours; the Chosen One for mute missions; Teacher with an abacus of silences; Lady of Honour of the useless; Mother of the eternal Cross...'

The titles of his works are the following:

1. *El sillón de ruedas* (1961) (preface by José Pérez Lozano and Antonio Castro).
2. *Dios habla todos las dias* (1962) (preface by Antronio Navarette).
3. *Mesa redonda con Dios* (1963) (preface by Francisco Javier Martin Abril).
4. *Las golondrinas nunca saben la hora* (1967) (preface by José Maria Pemán).
5. *Cartas con la señal de la cruz* (1967) (preface by P. Félix Garcìa).
6. *Reportajes desde la cumbre* (1969) (preface by P. J.M. Llanos).
7. *Bien venido amor* (1969) (preface to the second edition by Rafael Higueras).
8. *El árbol desnudo* (1970) (preface by various authors of the Catholic press).
9. *Las estrellas se ven de noche* (posthumous) (preface by Francisco Javier Martin Abril).

His literary work and output, which was fundamentally of a religious nature and character, is full of poetry, beauty, and tenderness.

He won a large number of literary prizes which he received with Franciscan simplicity. In 1969 the commune of Linares made him a chosen son of the town.

2. The Servant of God (an Invalid and a Blind Man) Gives his Life an Apostolic Dimension

One of the readers of the works of Lolo perceives in the chapter 'con la señal de la cruz' the thought of this Servant of God on pain: the joyous acceptance of the cross, the redemptive value of pain joined to the passion of Christ, and the purifying strength which springs from this acceptance. Lolo wrote about this in the following way: 'three approaches when faced with pain: that of the person who has not yet gone beyond the burning of his own wound: "God has abandoned me..."; that of the person who accepts it without, however, entering into the spirit of its meaningful activity: "God has asked me..."; and the person who understands the communitarian value of suffering and offers himself fully to the ideal of redemption: "Lord, I offer you..."'[1]

The profile of this Servant of God, who turned his wheelchair into a redemptive trial, undoubtedly had much to say to contemporary man, educated as he is in a society which gives itself up to easy pleasure and which has made today's average man lose the meaning of pain.

It is helpful to quote here the work *Reflexiones clinicas y antropológicas acerca de un paciente ejemplar Manuel Lozano Garrido*, written by Dr. Fermin Palma.[2]

Dr. Palma transcribed the following passage by the Servant of God: 'are you always in pain, always? Well, yes, always, always'.[3] And offered us this comment: 'always, always, always, the swallow flies and the river makes its noise, according to the poems by Lolo which Guillermo Sena summarises perfectly in "Scrutidor del alma"'.[4]

Always and perpetually pain, as all the authors, journalists and his friends have observed. From Robert de Taizé who would acclaim him as a 'sacrament of pain' to his biographers Juan Sánchez and Juan Rubio Fernández and many others who have been fascinated, without being aware of the fact, that both love and pain "derive from

the same wound", which becomes transformed into a source of thought, spiritual vigour, and life.

He feels the pain that does not 'fall asleep' before him. For this reason, in one of his pages he wrote, when talking about the Lord: 'How hard is anxiety, and I don't have to tell you this because you know about agony!'[5]

Without any doubt the most characteristic thing about this Servant of God was the very long time of his painful illness. He was an invalid and during the last years of his life he was also blind. During this infirmity he was accompanied by a set of permanent consequences which meant that he was always *at death's door*.

This Servant of God was a suffering worker or a sick person who worked. During his life hard work and acute illness intertwined in a single lattice. But during his life his profound devotion to the Eucharist made him live out his life in a way that was joined to the sacrifice of Christ. His daily work and his daily pain – like bread and wine – were joined to the Eucharistic sacrifice of Jesus Christ in the daily taking of the Eucharist.

Vatican Council II spoke about the sick and included them within the universal call to holiness: 'we know that they are also joined in a special way to Christ, who suffers for the salvation of the world...'[6] The immense force of human pain cannot be useless. The redemptive action has its supreme expression in the Cross of Christ. 'For this reason in the Christian life the encounter between pain and love should be achieved, linked together in the Cross of Christ. All this pain should be accepted with love so that it is redemptive and leads to the fullness of life'.[7]

Perhaps for this reason the most abundant literary output to come out of the pen of this Servant of God was that of trying to engage in a Christian reflection on pain. This is what he tried to do in his first book, *El sillón de ruedas*. But another book of his, *Cartas con la señal de la Cruz*, is engaged in the same undertaking. In this work he describes a Via Crucis, and comments on the four stations of the cross and adds the same number of letters addressed to sick people.[8]

The review *Sinai*[9] had this aim and purpose. It wanted to unite the pain of all the sick people who belonged to this *apostolic work* to offer up their suffering through the Catholic press. For this reason, in all the issues of this review, there are writings by our Servant of God on the value of pain, as there are also in the twenty-three articles published in *Enfermos Misioneros*.[10]

The subject of pain is ever present in his diary-books: *Dios hablas todos los dias*, *Las golondrinas nunca saben la hora*, and *Las estrellas se ven de noche*.

3. The Experience of Pain Beginning with the Faith

However, more than what this Servant of God wrote about pain, it was his experience of pain that really mattered – that is to say how this Servant of God lived out his 'identity' as a sick person.

The witnesses at the inquiry speak about the home in which he lived, in which he received care and treatment, and where he often had to stop working because his illness had become very acute.[11]

This Servant of God saw pain as a path of redemption. He saw his illness as a gift of God: 'finally, I fall on my knees and give free expression to my gratitude... I do not want to complain. Bring me, in exchange, your smile and allow joy to place garlands and roses on my heart because it is here that there is the fragrance of the heart which supports the architecture of suffering'. He then began to draw up *a list of benefits*: the proximity to God who searches for him, faith, providence, spiritual care, affection, personal vocation... because 'if one road closes He offers the resource of other lateral paths which then take its place'.[12]

This Servant of God entitled one of the chapters of his book *El sillón de ruedas* in the following way: 'El dolor se arrodilla'.[13] What he writes about here is his life – he lived acceptance of pain in such a way that he would one day publish his 'Credo of Suffering'.

4. The Exulting Joy of the Servant of God in his Pain

'What is joy', this Servant of God asked in an article published in *Vida Nueva*.[14] And he provided the following answer: 'joy is a vital manifestation of man and thus of essential importance in his growth and development'. He later quoted Bernanos: 'there is a joy in God and a poorer joy'. In the accounts of his death there were present ideas which had been spread through his writings – 'I am yours and I renew my appointment with you in Joy'. 'Joy' with a capital letter; the Joy that is Christ and the Joy that is the encounter with the Father.

All the witnesses at the inquiry have spoken about the joy, the smile, the good humour, and the good spirits of this Servant of God. He wrote: 'above embittered or sugary men, beyond the silences or the lips open to song, we must believe that jubilation moves man as a product of a tendency and an ascension: joy is the fruit of a conquest...' And he added: 'Christianity is above all else an operation of joy'.[15]

This Servant of God constantly expressed and transmitted this joy.

In a metaphor which described his life: 'with a life which lights up little more than a very short candle, I believe in your spring... Now, tomorrow and always, I believe in God, who has given spring to us and has made all springs possible'.[16] This is what this Servant of God wrote when he felt that his life was drawing to an end. This passage was written in his posthumous book, the proofs of which were handed over to him a few minutes before his death when he was already in the eternal spring of the encounter with God.

5. 'Supernatural Naturalness'

All people can reach holiness given that God himself imposes it on everyone. As J. Urteaga said: 'God will not ask of everyone a holiness with extraordinary forms of prophecies and miracles, but the holiness of doing extraordinarily well the ordinary and usual things of every day'.[17] But this doing of ordi-

nary things extraordinarily well does not remove the fact that 'circumstances and the context treat you with harshness'.[18]

This aspect of 'naturalness' which this Servant of God demonstrated when doing the *ordinary*, he saw as the constant of his days: 'I live my uselessness with a characteristic of normality, in the same way as a person is born with red hair or with a vocation to be a machine operator'.[19]

This Servant of God, aware as he was of the fact that his illness was a gift of God, took it upon himself as such and accepted it. 'He transmitted an impression of naturalness which made what appeared in him to be a very harsh trial to be natural. This was a trial that he bore with kindness, with the grace of God... The admirable thing about Lolo is that his life, the same day after day, made him live the ordinary of every day in an extraordinary way. And he lived in an ordinary way the extraordinariness of his pain, of his invalid state, without giving importance to them'.[20]

To conclude this paper, perhaps it would be opportune to quote some of his other texts.

The first of his diary-books ends with a number of pages of conversation with the Lord about faith and hope. 'I must dream of seeing you, I will die because I do not see you and you will go on being protected by seven veils, always hidden and unreachable... I say more to you than I do not say... that every tear is worth an act of laughter; pain is worth a consolation; night is worth a mid-day. Thus it is faith which asks for alms. Like hope as well... Thus the hunger for faith tears at me, burning and purified faith'.[21] In this passage, as in so man others, we can appreciate his faith as a contemplative who looks for, and wants the God that he has felt.

Twelve years before his death on 3 November 1959, the same day that he died, he wrote another of the many passages on the worsening of his illness: 'after two months of silence, now, Lord, my diary is in front of you. You opened readily, with jubilation, just as an early flower in the pots on my balcony do, Today the day is like a station shelter when the train arrives a friend gets off who we have not seen for a long time. You are here, seated next to my wheelchair, and with affection I put my arm around your shoulders...'[22]

When this Servant of God wrote these words twelve years still had to pass before this blind man came to see *the spring which had been wished for so often* of the final encounter with the Lord; twelve years when a path of immobility as a paralytic passed 'in a hurry', together with the Friend who had arrived and was there, sitting next to the wheelchair. At the end of these twelve years he finally came to the encounter with the Lord which had been so often wished for.

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Notes

[1] M.L. GARRIDO, *Las estrella se ven denoche* (Bilbao, 1973), p. 102.
[2] F. PALMA, *Reflexiones clinicas y antropólogicas acerca de un paciente ejemplar Manuel Lozano Garrido* (Zamora, 1998), p. 18.
[3] M.L. GARRIDO, *Dios habla todos los dias* (Bilbao, 1967), p. 146.
[4] M.L. GARRIDO, *Surtidor del alma* (La Carolina, 1997), p. 36.
[5] M.L. GARRIDO, *Las golondrinas nunca saben lahora* (Bilbao, 1967), p. 152.
[6] Vatican Council II, *LG*, n. 41.
[7] B. J. DUQUE, 'Universal vocación a santitad', in *Comentarios a la Constitución L.C.* (Madrid, BAC, 1996), p. 775.
[8] M.L. GARRIDO, *Cartas con la señal de la Cruz* (Bilbao, 1967), pp. 149-196 and 29-103.
[9] Summ., *Pars altera*, V, pp. 249-258.
[10] Cf. C.P., *Proc. Supl.*, Vol. V., pp. 28-30 and 88-135.
[11] Cf. Summ., *Proc. Ord.*, XI witness, Maria dolores Muñoz, p. 70, n. 217; cf. *Proc. Ord.* VII witness, José Ganzàlez, p. 51, b. 163; Proc. Supl., VII witness, Antonio Maldonado Trigueros, p. 152, n. 477.
[12] M.L. GARRIDO, *El sillón de ruedas*, pp. 7, 19, 72, 88.
[13] M.L. Garrido, *El sillón de ruedas*, p. 267.
[14] *Vida Nueva*, 1 December 1957.
[15] M.L. GARRIDO, *El sillón de ruedas*, pp. 203 and 205.
[16] M.L. GARRIDO, *Las estrellas se ven de noche* (Bilbao, 1973), p. 309.
[17] J. URTEGA, *El valor divino de lo humano* (Edic. Rialp, Madrid, 1959), p. 49.
[18] J. URTEAGA, *op. cit.*, p. 72.
[19] M.L. GARRIDO, *Dios habla todos los dias* (Bilbao, 1967), p. 20.
[20] Summ., *Proc. supl.*, V witness, Carmen Troyano, p. 136, n. 429 and p. 138, n. 436; cf. XI witness, Esperanza Fortes, p. 174, n. 538.
[21] M.L. GARRIDO, *Dios habla todos los dias* (Bilbao, 1967), pp. 238-240.
[22] M.L. GARRIDO, *op. cit.*, p. 167.

The Hospital of the Holy Spirit of Rome as an Example of the Apostolate of Compassion[1]

1. Brief References to the Order, and the Hospital, of the Holy Spirit

In the history of the development of the various forms of activity and initiatives of a charitable character, inspired in a decisive way for almost eighteen centuries until the Enlightenment by the Christian teaching on compassion, the foundation of the Hospiteller Order of the Holy Spirit towards the end of the twelfth century was an event of fundamental importance and significance. This Order was founded in Provence by Guidone di Montpellier and was called the 'Ordo Fratrum Canonicorum Regularium Sancti Spiritus'. Even though it was one of the many charitable and knight-hospiteller Orders which arose in the eleventh and twelfth centuries, nonetheless, with its rapid development, the breadth of the organisation of its works and initiatives, and the variety of its forms and expressions, it dominated in a decisive fashion the other Orders dedicated to similar ends and missions. The activity of the Order of the Holy Spirit represented an epoch all of its own, not only in the history of compassion and charitable works but also in the whole of Christian civilisation and medieval culture.

The undisputed symbol of the power and leading role of this Order in the field of charitable works in medieval Europe was the Hospital of the Holy Spirit, which was founded by Pope Innocent III between 1198 and 1201 in Rome, on the site of the previous Schools of the Saxons, and entrusted to the religious of the Holy Spirit. From the beginning of its existence, this hospital was the most famous and largest charitable centre in Europe, and was also a model and example for the hospitals which rapidly developed during that period which were administered by the religious of both the Holy Spirit and of other Orders, or founded by secular and ecclesial institutions, brotherhoods, cities, and corporations. The social care and charitable activity which were expressed above all in the foundation of hospiteller Orders were, during the medieval period, a fundamental task and responsibility of the Church. The ecclesiastical charitable undertakings, side by side with the foundation of Orders, schools, and universities, were one of the fundamental characteristic trends of the culture of that time. The development of hospital activity drew inspiration from ascetic philosophy and the medieval mentality, according to which the *peuperes*, and thus all people in need, enjoyed general acceptance and even glorification on the part of the Church and society.

The large size and the extension of the Roman Hospital of the Holy Spirit was expressed not only in the monumental character and dimensions of its buildings but also in the fact that it was always the mother house of the religious of the Holy Spirit and the headquarters of their Superior General. For almost the whole of its existence, that is to say until the unification of Italy in 1870, it was constantly under the care and protection of the Pope, and for this reason it was called a 'pontifical arch-hospital'. There was nothing like the Hospital of the Holy Spirit of Rome, neither during the medieval period nor during modern times, when, after the restoration work carried out at the end of the fifteenth century, and the later investments made during the sixteenth century it enjoyed its period of greatest splendour. Despite radical changes which were connected with its forms of administration and management, it has maintained its level and standing right up until the present day and is one of the most important and largest institutes of health care in contemporary Rome.

During the first three centuries of its existence (the twelfth to the fourteenth centuries) the hospital acted above all else in order to deal with the needs of the sick and the poor. However, the taking care of abandoned children was also a prominent and integral part of its activities. This function of the hospital is not directly described in the documentary evidence that is available to us. After the refoundation of the Hospital and its extension carried out by Sistus IV during the fifteenth century, two institutions existed within the hospital, fully connected to each other but with different functions – the hospital proper for the sick and the hospice for the foundlings. The hospital of the Holy Spirit, as a centre of health care, was not only concerned with the care and treatment of sick people – it was also a great medical centre and centre for medical studies, and was indeed equipped with the famous Lancisian Library and a medical academy. Within its walls there also existed a brotherhood of charity and a bank which bore the same name as the hospital. During certain periods the administration and management of lesser hospitals in Rome depended on that provided by the Hospital of the Holy Spirit. The hospital for children afflicted with mental illness, among other maladies, formed a part of its wider complex.

Even though the activities of the part of the hospital which was responsible for care and treatment has not so far been studied in the least, that topic will not be the subject of this paper. This study will, instead, dwell upon the hospice for abandoned children (the 'brefotrofio' or 'foundlings hospital') which existed within the confines of the Hospital of the Holy Spirit.

2. The Abandonment of Children

In the investigations into the history of the provision of social care a fundamental role is attributed, in the course of history, to the problem and issue of un-

wanted children, usually newborn and called 'foundlings' or 'abandoned children', who were present above all else in the great European cities. This was a special category of people in need who were particularly weak. Not receiving any immediate help, they had no chance of survival. For this reason, saving abandoned children and looking after them was one of the most important missions of Christian philanthropy and charity.

The abandonment of children was practised on a large scale in the times prior to Christianity. Newly born children were abandoned in secret. Given that their destiny was surrounded in mystery, and easily the matter of legend and superstition, to the foundling was applied the rooted popular belief that at the height of misfortune there was always the possibility of changing one's destiny. Romulus and Remus, the founders of a civilisation, and Moses, for example, were foundlings who have inspired our imaginations.[2]

In the Roman culture of the second and third centuries the newly born child was placed on the ground and if the father, or the master of the slave-mother, took it up it was fed and brought up. Otherwise, it was placed outside the door or actually abandoned.[3] The decrees of Constantine of 331 and of Onorius and Theodosius of 412 entrusted foundlings to those people who found them and gave them the option of deeming them free or slaves. But many were found and educated by the Church, which generally was engaged in providing these young people with a trade, as was done with orphans, so that they would then be able to maintain themselves in an economic sense. As for the girl orphans, in addition to being maintained them they were also provided with a marriage dowry in order to keep them away from prostitution.[4]

During the medieval period care for abandoned children was not something specifically dealt with within the system of organisations and institutions of the Church. Usually unwanted children were left in churches, in monasteries, or were sold, or were entrusted to outside people or families. Until the end of the twelfth century taking care of foundlings was a matter of chance or accident, and was largely a matter for private individuals.[5] A radical change took place at the beginning of the thirteenth century when in the great and small cities of Europe there began to arise and rapidly spread hospitals, hospices, and foundling hospitals exclusively for foundlings, one of whose principal missions was to provide care to these abandoned children.[6] Most of the institutions of this kind were hospitals run by the largest and most important charitable religious order of the medieval period – the Order of the Holy Spirit.

The number of abandoned newly born children was to increase even more with the advent of the modern age. This was especially the case in France, Spain and Italy. In the eighteenth century the phenomenon of the abandoning of children exploded and displayed a striking increase in numbers. Indeed, the eighteenth century is spoken of as 'the century of the foundlings'.[7] The foundlings hospital was one of the typical foundations of this century and every large city built its own institution for this purpose. Indeed, this process was so widespread that in Europe 356 such institutions existed in the middle of the nineteenth century with more than 460,000 children being cared for within their walls.[8]

Amongst the institutions created to look after foundlings the hospital of the Holy Spirit in Rome enjoyed a particularly prominent profile. With the passing of time all the centres managed by the Order of the Holy Spirit as well as other institutions responsible for this category of people in need based themselves upon the model and example of this particular hospital. This system may be adjudged to be complete because it guaranteed care for these foundlings for the whole of their lives.

My work of research for the most part concerns the eighteenth century which from a European point of view may be defined as the century of 'the Enlightenment'. The choice was dictated only in part by merely practical considerations, above all because of the fact that the documentary evidence which survives to us is much richer for the eighteenth century than for previous centuries. As *terminus ante quem* the end of the eighteenth century was chosen, the time of the birth of the Roman Republic and the occupation of the Papal States by Napoleon. Furthermore, the turn of the century was a clear break in terms of the development of hospital care and social provision throughout Europe. From that moment onwards there began the rapid process of the state assuming responsibility for hospitals or their being given over to an independent board made up of municipal representatives. From that specific moment, furthermore, the previous hospitals, which were usually hospices, began in general to be transformed into centres of health care.

The documentary evidence on the hospital amounts to more than three thousand volumes and large files which are kept in the State Archives of Rome.[9]

3. The Welcoming of Foundlings into the Hospital

The initial idea of Innocent III was that the hospital-hospice of the Holy Spirit should be for illegitimate children and such was the case. However, in practice a large part of the abandoned children were legitimate children. Poverty and the illness and physical defects of the newly born children were the serious reasons which led mothers to abandon their children.[10] During the seventeenth century about a thousand children every year ended up in the Hospital of the Holy Spirit. During the eighteenth century this annual

figure was much lower in size (500-700). The abandoned children came in particular from the towns and villages within a range of a hundred kilometres from Rome.[11]

The buildings and the structures of the hospital were designed so as to guarantee the people who abandoned their children absolute discretion. The children were usually brought to the hospital during the night or at dusk or dawn, a reality which made anonymity easier. The children were left in a wooden box which was large and round, rather like a barrel, and which was known by the name of 'the wheel'. It was built into the external walls of the hospital. The person who brought the child placed it within this box through an opening, turned it round, and then rung a bell so as to alert the person on duty by day or night within the hospital.[12] To ensure that the women who abandoned their children were safe in what they were doing and could enjoy a certain privacy, thereby avoiding dishonour, the papal authorities took them under their protection and for example prohibited the representatives of the public services from applying any sanctions to such women.[13] Afterwards the 'wheel' was opened with a key and the child was taken out, the person on duty used a lancet to incise a double cross on the child's right foot. This was the sign of the hospital and of the Order of the Holy Spirit as well. When the cut of this mark was still fresh it was filled with a black dye which made it more evident and which gave it the character of a tattoo or even of a brand.[14]

The children which had been left to the hospital were breast-fed by wet nurses who went there specifically for the purpose, the so-called 'house wet-nurses'. After a short stay in the hospital the children were entrusted to women who lived outside the hospital to be fed and brought up, these were the so-called 'outside wet-nurses'. These nurses were given a monthly allowance of money and clothes to look after these children. Those women who decided to adopt the role of full wet-nurses in their homes were subjected to rigorous conditions by the hospital with regard to their health, their lifestyle, their morality, the religious character of their lives, and their economic condition. Because of better conditions as regards climate and mores, wet-nurses from outside Rome were preferred.

After a period of stay with these wet-nurses the abandoned children had without any reservation be handed back to the hospice – the girls before the age of eleven and the boys before the age of twelve. After going back to the hospital the girls (called 'spinsters') were placed in the Conservatory and the boys went to the 'Scuola dei Putti'. The boys did not stay for a long time in this school – very soon they were entrusted to the care of artisans so that they could learn a trade or skill. About 30-50 boys were in this school. The situation was different for the girls who were only rarely entrusted to outside people, and for this reason there were always about 400-700 girls in the Conservatory.[15] Furthermore, both the girls and the boys were sometimes given to people in adoption.

4. The Conservatory

When wanting to outline the daily life of the spinsters and describe the internal structure and the management of the hospice, one cannot avoid talking about the role from this point of view that was played by the nuns of the Congregation of the Holy Spirit. During the first five centuries of the existence of the hospital these nuns were closely bound up with the working of the Conservatory and with the life of the pupils. These nuns, resident in the hospital founded in 1198 by Pope Innocent III and subject to the rule of St. Augustine, from the outset had to help sick people and foundlings.[16] All the nuns in the convent were the highest authority for all the pupils entrusted to their care. Their task consisted in the main in teaching the pupils various kinds of trades and skills, in looking over them as they did so, and in ensuring that things went well in this sphere. Until the end of the 1760s these nuns had total and absolute power over these pupils. For their pupils these nuns were thus administrators, educators, tutors, teachers, catechists and even nurses and directors who monitored and controlled their activity. With the reforms carried out in 1666 by Commendatore F.M. Fabei, these nuns, who for some centuries had governed the Conservatory, no longer did so. Their transfer to another place and their subjection to a rigid life of seclusion in order to prevent other admissions into their congregation condemned them to natural extinction.[17] From the end of the 1760s the direction of the Conservatory was totally in the hands of female members of the laity, who were themselves often former pupils of the Conservatory.[18]

The life of the girls in the Conservatory was rigorously regulated by the higher authorities of the hospital and the Church. The girl foundlings, from the moment that they entered the walls of the hospital and for all the time that they remained within the institution, were obliged to observe its regulations and to carry out tasks of various kinds established by their superiors or by the hospital authorities. In particular, in the hospital an attempt was made to instill good habits and to develop the morality of the boarders. Taking account of the great moral dangers to which the girls would have been exposed from too great a freedom or a lightness in contacts and conversations with outside people, and indeed with the internal male religious or secular staff and personnel, it was decided that the members of the Conservatory would be subject to a very severe system of seclusion.[19] Strict seclusion for these girls was maintained from the beginning of the creation of the Conservatory and did not in the least diminish after the spinsters had been separated from the nuns or after the recruitment of nuns for the congregation had been terminated.

The principle of the life of seclusion of these girls was put into practice not only through prohibiting people from outside the confines of the Conservatory from coming within its precincts but also through a rigorous prohibitory edict on the formation of any kind of contact with the outside world by the same girl boarders. During the

eighteenth century instructions on more than one occasion were given to the girls not to approach the main gate of the Conservatory under any pretext without having previously obtained the permission of the mother superior or the commissioner of the hospital.[20]

From the analyses which have been carried out, it can be deduced that the spinsters of the Conservatory lived in total seclusion, and indeed were isolated from the external world. Those who did not marry and decided not to go out to work were deprived of all contact with the rest of society and thus spent the whole of their lives in the Conservatory in a state of complete separation. The only

opportunities the boarders had to go out officially from the walls of the Conservatory took place three times a year at the time of the solemn processions to the basilica of St. Peter's. These took place on Pentecost, St. Mark's day, and the Sunday before the solemn feast of St. Anthony.[21] As was the case during the medieval period, in the period after the Council of Trent, as well, the hospitals, like the other institutions under the direct administration and management of the Church, were places where not only the illness but also the religious life of those who were admitted was looked after and taken responsibility for. This was the norm in general which was followed in the hospitals managed and administered by religious orders, but the Hospital of the Holy Spirit of Rome requires special attention because it was linked to the full to the institutions of the Order of the Holy Spirit where the spiritual and religious way of life was laid down by the monks and nuns.[22]

In 25 December 1623 friar Domenico Borguracci, the secretary and archivist of the Order of the Holy Spirit, when drawing up the rules and regulations, suggested to the religious of the Order of the Holy Spirit the way in which the hospital should be governed, and expressed the following opinion: 'so that the sick people and foundlings who daily come to be looked after in this apostolic archhospital of the Holy Spirit, can be in the right ways governed and helped both in the service of the soul and of the body...'[23] The hospital was made up of two separate institutions but had a unified and single administration. These institutions were: the hospital for the sick on the one hand and the hospice for the abandoned children on the other. According to the above mentioned rule of 1623, the sick person, as soon as he or she had arrived in the hospital and immediately after being subjected to the preliminary medical examinations, had to immediately engage in confession with one of the four confessors on duty and on the next day he or she had also to receive holy communion.[24]

In the case of the sick, the authorities of the hospital confined themselves to requiring of them the obligation to receive Holy Communion only for the period of their stay for treatment and recovery. The case was different for the foundlings. From the very moment of the abandonment of the child at the 'wheel', the hospital became responsible for his or her upbringing and education and in particular for his or her religious and spiritual training.[25] The interest of the authorities of the hospital in the religious life of its pupils also continued after the period when they were entrusted to the wet-nurses, when they were given to people *ad artem* or *a tempo nubile*, and in the case of marriage. In practice, this interest was due to the fact that the hospital wanted all the wet-nurses, all the artists, artisans, potential husbands, and the families which adopted these girls, to be marked out by sound morality, good conduct mores, and a zealous profession of the Catholic faith.[26] The abandoned children were received into the Catholic community through baptism, which they received immediately after being accepted into the hospital.[27] With rare exceptions almost all the foundlings, after a short stay in the foundlings hospital, were entrusted to 'outside' wet-nurses with whom they spent about ten years of their lives. In their homes these foundlings were instructed in the basics of the faith.

After about ten years with the wet nurses the foundlings returned to the hospital. From that moment until their final exit from the hospital (adoption, guardianship *a tempo nubile*, guardianship *ad artem*, marriage), their education was exclusively in the hands of their immediate superiors who were for the most part ecclesiastics and religious.

As was the case with all Catholics, in the case of the boarders of the Hospital of the Holy Spirit as well one of the most important events in the process of formation was the first communion. This is borne out by the order of Commendatore Virgilio Spada of 1660, according to which all the spinsters who were reaching their twelfth birthday at Lent had to prepare for their first communion, which took place on Easter day.[28] Frequent and regular taking part in the sacraments of confession and the Eucharist was the most important religious activity of the boarders of the Conservatory. This was rigorously directed through the

regulations and depended above all else on the age of the spinsters. According to the orders of 1660, the resident spinsters and the nuns of the convent had to regard confession as the highest good and as a practice which guaranteed the salvation of the soul.[29]

Taking part in the holy sacraments, and in particular the sacraments of penitence and communion, was only one of the forms of the education and the religious life of the 'spinsters of the Conservatory'. The register of the obligatory religious and spiritual activities of the hospital was unusually rich and complete. Living together with the nuns of the Holy Spirit, the spinsters almost behaved like nuns, and based their lifestyles on the monastic spirit. Their daily tasks, such as work and their religious activities, followed the same lines. For this reason, the religious life of the spinsters, the enforced seclusion, and their clothes, all made their existence similar in character to that of the monastic life. This state of affairs, in this area, did not change even when the spinsters were separated from the nuns.

At the beginning of the eighteenth century, Pope Clement XI imposed regulations regarding the timetable for the daily tasks and activities of the spinsters and sought to lay down the category of religious practices envisaged for them. In general, the character and time of the carrying out of these practices depended on the age of the spinsters involved. The elderly and middle-aged spinsters, with the exception of the sick and those unable to work, woke in the morning at the sounding of the 'Hail Mary' bell and then went to church to attend mass, make their devotions, and engage in the 'divine office of the choir'. After these undertakings, they went to the dining hall for their breakfast and afterwards engaged in their usual manual work. During this work they sung together the praises of the Blessed Virgin Mary. The pause between their morning and their afternoon work was taken up by lunch. After their afternoon work the elderly and middle-aged spinsters had supper and afterwards went to the chapel to recite the same prayers as had been recited in the morning. It seems that the spinsters did not have any free time reserved to themselves during the day – everything was planned with extraordinary detail and scruple. The above mentioned regulations also referred briefly to the religious duties of the youngest spinsters but it is directly clear from these regulations that the youngest girls did their evening devotions in their dormitories.[30]

The periodic organisation of 'spiritual retreats' formed an important part of the care of souls. For example, the 'spiritual exercises' in the hospital of the Holy Spirit took place between 16 and 29 May during the year 1760.[31] Given the very important role of spiritual life in the hospital, in order to make the religious practice more solemn in character the creation of a liturgical choir was requested which was to accompany most of the religious ceremonies which took place in the Conservatory and the hospital. This choir also sang during the saying of prayers and the offices. The principal task of the choir was to recite and sing various prayers (for example psalms) during the shared functions and the offices.[32]

From these related facts it emerges that the hospital of the Holy Spirit was not only given the role of looking after health – it also had a pastoral and educational responsibility. The life of those living in the hospital had to be imbued with a spirit of zealous religiousity and devotion, with every action and moment of the day being regulated.

The education of the pupils of the Conservatory had to take place through the development of spiritual and religious life as well as through daily work. In 1679 Cardinal Acciajoli, referring to the decrees of Pope Urban VIII and Alexander VI, ordered all those who lived inside the Conservatory, according to their age and capacities, to dedicate their whole time to various kinds of work to the benefit of the hospital and thereby to engage in works of Christian compassion, prayer, and spiritual exercises.[33]

The obligation to work every day applied to all the female boarders in the hospital with the exception of those who were sick and very elderly women. Work was seen above all else in terms of its educational, social and utility value. In involving the female boarders in tasks of various kinds an attempt was being made to train them in hard work, honesty and discipline, to teach them various kinds of trades and skills as well as house work which would be useful to them when they were married and had to run a home. Their work also had a real economic and material value.

One of the most detailed lists of the activity carried out by the girls and women living in the hospice is to be found in docu-

ments from the year 1660. From these it can be deduced that the female boarders cooked, washed clothes and dried, ironed, mended shirts, amices, surplices, gloves, purificators, and the liturgical vestments of the church of the hospital, as well as the underclothes of the patients. In addition, they made sheets, tablecloths, napkins, and other things that were necessary for employees of the hospital, shirts, sashes, and ribbons for all the foundlings, both those who lived in the hospice and those who lives with wet-nurses. They also cut and sewed clothes, blouses, sleeves and socks for themselves and for the nuns who lived in the convent.[34] In addition to the above mentioned productive work, at the beginning of the 1760s the spinsters helped in, served in, and cleaned the hospital. Six of them worked for a week in the kitchen to prepare the meals of all their companions in the Conservatory, and the week afterwards dedicated themselves to cleaning the

clothes of all the members of the Conservatory. Every seven days the area of work changed. Four or six women also helped the nuns in their work of administration and management.[35]

The professional activity of the female boarders was one of the principal tasks of their education. Each of them had to carry out certain functions, and had to make themselves useful according to their abilities, age and physical condition.

The reality of seclusion of the daily lives of the female boarders was also expressed in the fact that they wore the clothes prescribed by the rules and regulations, and these clothes were similar to those worn by the nuns. The principal characteristic of the clothes of the female boarders was their uniformity, simplicity, and modesty. According to the regulations and the ordinances, which were often renewed, uniformity of dress was obligatory for all the female boarders, irrespective of age or physical condition, both within the precincts and during the rare trips outside the hospital and during the visits and the processions.[36]

The order to wear the uniform applied to clothes, shoes, and bonnets, as well as to hairstyles. In special and justified cases the management of the hospital allowed some female boarders to wear clothes etc. which did not belong to the uniform. This largely applied to the boarders engaged in heavy work and difficult jobs where the uniform was not appropriate.[37] The uniform and modest clothes were suited to the monastic style of life of the female boarders and the religious-sacred character of the place where they lived. In living for a number of centuries with the nuns in a shared convent they took on from the nuns with whom they lived not only the habits and customs of the life of seclusion but also its conformity, simplicity, and the severity of its way of dressing. Wearing a uniform set of clothes according to the founders had an educational purpose – it was something intended to teach modesty and moderation to the boarders: virtues which would be useful in their future adult lives as well as acting to impede the acquisition of vanity and bad habits.

The essential feature of the daily uniform of the boarders was a dark blue dress which was similar to a religious set of clothes. This was how they had to be dressed inside the precincts of the institution as well as during the processions which were held three times a year and which took place in the streets of the city.[38]

5. The Boys School

Boys who were at least seven years old lived in the school for boys. The youngest boys, on the other hand, who previously had returned from the custody of their adoptive families, stayed with the wet nurses of the hospital until reaching that age. According to the rules of 1759, the abandoned children could be maintained and brought up in their own school at the expense of the hospital until they were twelve years age and were then given in adoption or *ad artem*. Only those few for whom people could not be found to entrust them to outside the hospital had the right to stay further within the hospital until suitable guardians were found for them or families who wanted to adopt them were identified.

The Hospital of the Holy Spirit provided initial help and refuge to all the foundlings irrespective of whether they were boys or girls. However, the girls and adult women received a more specific form of care and approach. In the sources we have available there are no references to adult male boarders, former foundlings that is to say who lived in the precincts of the hospital institution. Hence, indeed, the name: the phrase 'Scuola dei putti' in Italian clearly indicates that only small boys were present. The stay in the hospital, which usually lasted a few months or years, was only a brief episode in their lives. From the moment of their adoption or their guardianship by which they could learn a trade or skill, their ties and connections with the hospital were broken for ever. Indeed, the hospital, given the nature of its buildings and organisation, was not intended to provide services over a long period, places to live, jobs, education, or income to adult men. The situation was different for women whose numerous and permanent presence within the complex was envisaged from the beginning and was in addition an indispensable condition for the effective and sound working of the whole institution.

The direction and the surveillance of the school for children without families was in the hands of an elderly priest who had the qualification of a teacher or a schoolmaster. In addition to looking after general order and discipline, he had the duty to teach the boys twice a day, in the morning and after lunch. He taught them to read and write, grammar, the catechesis, compassion and Christian piety, as well as instilling in them good habits and the bases of a sound education. He was also obliged to organise the daily work of service and order for the good of the hospital, the school and the church, in which the boys above all else performed the function of altar boys. He also had to be responsible for the health of the boys and to send them to be treated if they fell ill.[39]

Differently from the girls who learnt the practical arts which prepared them for adult life within the Conservatory, the boys received their professional training outside the precincts of the hospital. This did not mean that all the male pupils of the foundling school, without any exception, completed their education of knowing how to read and write, their course of catechesis, or in a more distant future the practical learning of a trade or skill. Some of them – the more intelligent – as was the case with the students of other charity centre in Rome, were entrusted to higher education or to the priesthood. In such a situation they left the walls of the hospital of the Holy Spirit and were then sent to suitable institutions for further education.[40] The rule of 1587 of Commendatore G.B. Ruini is proof that the superiors of the hospital occupied themselves with enabling the more talented boys to acquire a broader education so that in the future they could obtain higher positions within society.[41]

6. The Subsequent Destiny of the Foundlings

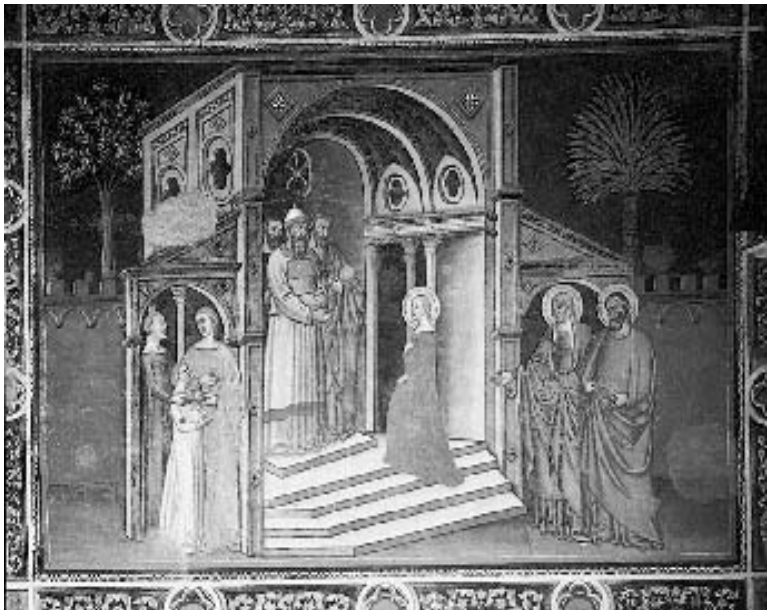
During the whole of their stay

in the homes of the wet nurses, the abandoned children continued to be under the constant supervision of the hospital of the Holy Spirit. The wet-nurses as a rule had no rights in relation to them, indeed the tie between the children and the families to which they were entrusted had a temporary character and arose on the whole from economic needs. With the passing of time these relationships increasingly acquired a familial and emotional character. Between the children and their guardians a relationship of love, cordiality, and affection developed.[42] As a result, many wet-nurses expressed the wish to go on looking after the children that had been entrusted to them.

According to the proposals made by potential guardians, three forms of looking after the foundlings were possible. The first was adoption, which in a strong and lasting way linked the children to their future step-parents. After adoption the foundlings acquired the rights which were possessed by the children who were born to their families and brought up in them. Another form of wardship allowed for the female foundlings was that of their being entrusted *a tempo nubile* to serve in a family where they stayed until they got married and became independent. The people who offered this kind of guardianship undertook to guarantee these girls lodgings, food, education and maintenance until they were married. Formally, however, the girls remained under the tutelage of the hospital and had the possibility of going back to it whenever they wanted. The entrusting of the boys *ad artem*, above all else to artisans, was similar to the system whereby the girls were given *a tempo nubile*.[43] The most convenient and welcome age, in the view of the authorities of the hospital, to begin to learn a profession, was 'about thirteen years old'.[44]

It was a long-standing custom that the women or their families who had looked after an abandoned child for eleven or twelve years and wanted to receive them under one of the forms of guardianship had to first give back the child to the hospital.[45]

Both adoption and guardianship *ad artem* or *a tempo nubile* were made legal by a contract between the hospital and the guardians or adoptive parents. In the case of girls given *a tempo nubile* and the boys given *ad artem* once again all the duties of the new guardians or adopted parents towards the children were listed in detail. They were obliged to maintain the children in their own homes, to clothe them, to give them meals at the family table, to treat them well, to teach them and to make them live the rudiments of the Catholic faith, and to habituate them to good mores, honesty, and moral principles, and also when they fell ill to make sure that they had treatment and care. They could not mistreat them, evict them, or give rise to situations where the children fled from the home which looked after them. In cases where a boy abandoned the home of his own free will the guardians had to find him and take him back home, informing, however, the hospital commission of the fact. In handing the girls over *a tempo nubile* the contract required that the guardians undertook to give these girls, by then teenagers, a dowry at the time of their marriage if one took place. In the signed agreement the hospital reserved to itself the right to decide on what happened to the adult girls who went on living in these homes – before deciding whether to marry or to become nuns they had to receive the consent or the approval of the hospital commission.[46]



The number of girls entrusted *a tempo nubile* each year was markedly lower during the first decade of the eighteenth century. During that period it rarely happened that ten girls a year were given out in service. A clear tendency can be observed for the subsequent decades. The highest number of spinsters given out by the hospital *a tempo nubile* took place in 1739 and amounted to ninety-nine girls.[47]

The adoption of the hospital girl pupils took place much more rarely. In the twenty-five years from 1711 to 1736 the disproportion between the number of girls sent out to service (664) and the number of girls who were adopted (73) was enormous. From 1737 to 1790 the cases of the adoption of girls was only a sporadic phenomenon – for this period the evidence reveals only twenty cases of adoption whereas the number of girls handed over *a tempo nubile* was about 1200. During the course of the whole century the girls who were adopted amounted to 7% of all the spinsters entrusted to the care of families who lived outside the hospital. Over a hundred years, all in all 2,050 girls were given out *a tempo nubile*, whereas 164 were adopted.

If one analyses what happened to the boys most of them were given to artisans so that they could learn a trade or skill rather than given out to adoption. The greatest dispropor-

tion in this sphere is to be observed for the period of the visit to the hospital for the years 1737-1740. The number of males adopted during this period (44) was four times lower than those handed over *ad artem* (183).[48] Generally, however, the difference between the two options for the lives for the boys was not as great as was the case with the case for the two options for the girls.

During the course of the eighteenth century the number of girls who were adopted or handed over *a tempo nubile* and of boys who were given out *ad artem* was 2,291 and 6,178 respectively.[49] Overall, therefore, in this period of a hundred years 8,469 abandoned children found adoptive parents, care, and work outside the hospital. It should be noted that in no year during the course of the whole of the eighteenth century did the number of girls handed over to service and adopted exceed the number of boys given over *ad artem* and in adoption.

The hope of the authorities of the hospital was to arrange things so that the highest possible number of their girl boarders became integrated into society in a positive way through marriage. But if the authorities left a great deal of independence and freedom to the boys in deciding about their own futures, they dedicated especial care and prudence to the future life of the adolescent girls. The cares and concerns of the management of the hospital regarding their future were expressed in the application of very severe requirements and conditions to those men who wanted to marry such girls. Indeed, all the men who wanted to marry the girl boarders had to be subjected first to rigorous kinds of tests and examinations.[50]

During the eighteenth century, each year 30 to 190 spinsters married, and during the whole of the century more than 7,000 girls of the Conservatory entered marriage. They married at a very early age, when they were about fourteen or fifteen. Usually, they married boys from the country or artisans who lived in small towns and villages. At the time of the marriage the hospital paid a dowry of a hundred scudos for each of its girl boarders.[51]

7. Conclusion

From its origins onwards, the Hospital of the Holy Spirit of Rome was the most important charitable institution in the Christian world. As a pontifical hospital it was for centuries a central point of interest for the Apostolic See and enjoyed protection and constant help which allowed it to continue to work during the period of the Reformation, something that was tragic in the European context for the hospitals run by the Order. Renewed and expanded in the fifteenth and sixteenth centuries, thanks to the interest of the Popes, the Roman hospital during the seventeenth and eighteenth centuries reached the high-point of its existence. For centuries all the other centres of the Order, as well as other institutions which were responsible for the same category of people in need, drew upon it because of the models and approaches which it developed. This was a complete system, which for those times was very modern, which guaranteed help, protection and education for abandoned children for the whole of their lives. Even though the foundlings usually spent only a certain part of their existence in the hospice, they nonetheless remained for the whole of their lives under its protection and supervision. The hospital opened its kind of umbrella of care for and defence of its former residents even after they had become independent and had founded their own families. About two thousand foundlings, both small and grown up, resident in the hospice, adopted, living in the families of their wet-nurse, in service with other people, apprentices of a trade or living with their own families, after getting married enjoyed at the same time, during the different stages of their lives, the help and protection provided by the hospital in its various forms. In general, the foundlings, who came from the hospital of the Holy Spirit of Rome and made up a social group with a certain profile which was both special and closed, were a life element in the villages and in the lives of the peasant women of the hinterland of the capital of the Papal States. Without doubt the Roman hospital carried out its mission to an extent which is not to be found elsewhere. During the seventeenth and eighteenth centuries it saved the lives of about a hundred thousand unwanted children. It is true that many of these in the months or years thereafter died but it should also be remembered that in those times death decimated the infant population, and this was not only the case within hospitals. One can argue that the system of protection of the foundlings introduced and practiced in the Hospital of the Holy Spirit of Rome was for those times an excellent solution, and above all else for the foundlings themselves. Thanks to this system, the children, deprived of their natural parents, could be brought up in a way which was almost normal in the substitute families. At the same time, for the inhabitants of Rome and its hinterland as well, the various forms of protection offered to the foundlings were from a material point of view a very remunerative occupation.

The problem of unwanted children, which has always been evident since ancient times, is also of relevance in our own days. A reflection is called for, namely that in order to solve this problem certain models and forms of experience developed by the Hospital of the Holy Spirit down the centuries could be useful, naturally after certain changes and after adapting them to contemporary needs and social realities. In this way, abandoned children would not risk ending up in rubbish dumps but would find themselves in a modern 'incubator' cradle.

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Notes

[1] More detailed information on the Hospital of the Holy Spirit and on its activities in relation to caring for abandoned children can be found in M. SURDACKI, *Dzieci porzucone w Szpitalu Swietego Ducha w Rzymie w XVIII wieku* (Lublin, 1998) ('The Foundlings of the Hospital of the Holy Spirit of Rome in the Eighteenth

Century') and in other works by the same author: 'Dzieci porzucone w Rzymie i okolicach w XVIII', *Roczniki Nauk Spolecznych*', 22, 1994, n. 2, pp. 84-108; *idem*, '"Figli legittimi" w Rzymie i Paqstwie Kocielnym w XVIII wieku', *Roczniki Nauk Spolecznych*, 23, 1995, n. 2, pp. 87-100; *idem*, Malzenstwa wychowanek Szpitala Swietego Ducha w Rzymie w XVII-XVIII wieku', *Kwartalnik Historii Kultury Materialnej*, 44, 1996, n. 2, pp. 137-156; *idem*, 'Marriages of wards of Rome's Holy Spirit Hospital in the 17th and 18th Centuries', *Acta Poloniae Historica*, 79, 1999, pp. 99-122; *idem*, 'Zycie religijne podopiecznych Szpitala swijtego Ducha w Rzymie w XVII i XVIII wieku', *Roczniki Nauk Spolecznych*, 24, 1996, n. 2, pp. 315-333; *idem*, 'La vita religiosa nel "Conservatorio" dell'ospedale di Santo Spirito in Roma nei secoli XVII-XVIII', *Ricerche di storia sociale religiosa di Roma*, 27, 1998, 54, pp. 149-165; *idem*, '"Bambini esposti" w Rzymie i w Paqstwie Kocilenym w XVII i XVIII wieku', in *Christianitas et Cultura Europae*. Ksijga Jubileuszowa Profesora Jerzego Kloczowskiego, vol. I (Lublin, 1998), pp. 148-157; *idem*, 'Kondycja zdrowotna podopiecznych Szpitala Swietego Ducha w Rzymie w XVII i XVIII wieku', *Roczniki Nauk Humanistycznych*, 46, 1998, n. 2, pp. 117-148; *idem*, 'Losy wychowankrw Szpitala wijtego Ducha w Rzymie w XVIII wieku', *Roczniki Nauk Spolecznych*, 25, 1997, n. 2, pp. 137-164; *idem*, 'Dzieci porzucone w rodzinach zastjpczych w Rzymie i okolicach w XVII i XVIII wieku', *Roczniki Humanistyczne*, 47, 1999, n. 2, pp. 125-148.

[2] G. Da Molin, *Nati e abbandonati. Aspetti demografici e sociali dell'infanzia abbandonata in Italia nell'età moderna* (Bari, 1993), p. 5.

[3] G. Pagliano, 'Il motivo dell'infante abbandonato in letteratura: Considerazioni su alcuni testi italiani', in *Enfance abandonnée et société en Europe XVI-XX siècle* (Rome, 1991), p. 879.

[4] V. Monachino, 'L'antichità e l'alto medioevo', in *La carità cristiana in Roma*, edited by V. Monachino (Bologna, 1968), p. 78. See also J. Boswell, *L'abbandono dei bambini in Europa occidentale* (Milan, 1991), p. 265.

[5] J. Boswell, *op. cit.*, pp. 25, 150, 256; G. De Rosa, 'L'emarginazione sociale in Calabria nell XVIII secolo: Il problema degli esposti', *Ricerche di storia sociale e religiosa*, 13, 1978, pp. 5-19

[6] L. Calzola, 'Caratteristiche demografiche di abbandono degli esposti dell'Ospedale di S. Maria della Misericordia di Perugia nei secoli XVI e XVII', in *Trovatelli e balie in Italia. Secc. XVI-XIX*, edited by G. Da Molin (Bari, 1994), p. 13; J. Boswell, *op. cit.*, p. 256.

[7] V. Hunecke, *I trovatelli di Milano. Bambini esposti e famiglie espositrici dal XVIII al XIX secolo* (Bologna, 1989), p. 15; idem, *Die Findelkinder von Mailand. Kinderaussetzung und aussehende Eltem vom 17. bis zum 19 Jahrhunderts* (Stuttgart, 1987); V. Paglia, *Storia dei poveri in occidente* (Milan, 1994), p. 327.

[8] V. Paglia, *op. cit.*, p. 327, J. Sandrin, *Enfants trouvès. Enfants oublihs. XVIII-XIX siècle* (Paris, 1968).

[9] Almost all the documents quoted and cited hereafter are to be found in the 'Archivio di Stato di Roma' ('Archivio dell'Ospedale di Santo Spirito di Roma'). The numbers in the references refer to the folders in which the documents quoted or cited are kept.

[10] See M. Surdacki, 'Figli legittimi', pp. 87-100.

[11] M. Surdacki, *Dzieci porzucone w Szpitalu*, pp. 106-118; *idem*, 'Dzieci porzucone w Rzymie', pp. 84-108.

[12] n. 1414B, 'Stato dell'officij, provi-

sioni, e salariati del Ven. Archiospedale di S. Spirito, tanto di Roma quanto di Campagna', p. 9; n. 1305, 'Regolamenti che si praticano nell'Archiospedale di Santo Spirito in Sassia di Roma per il buon Servizio di tutti gli esposti 1754'; n. 1305, 'Visita de Proietti ed utili 1740'. See also n. 1296, 'Intorno a quello spetta Monsignore Commendatore'; n. 1305, 'Regolamento per Baliatico. Regolamenti del Baliatico di S. Spirito'.

[13] C. Schiavoni, 'Gli infanti "esposti" (o "proietti") alla "ruota" dell'archiospedale di Santo Spirito in Saxia di Roma dal 1700 al 1824', in *La Demografia Storica delle Città Italiane* (S.I.DE.S., Bologna, 1982), p. 1028.

[14] *Ibidem*., p. 1028.

[15] M. Surdacki, *Dzieci porzucone w Szpitalu*, pp. 232-241, 335-350.

[16] n. 30, 'Notizie diverse di Casa in tempo di Monsignor Racagni', p. 5.

[17] C. Schiavoni, 'Gli infanti', p. 1040.

[18] n. 1305, 'Decreti di Visita dell'Eminentissimo Cardinal Acciajoli 15 giugno 1679', in 'Notificazione sopra varie providenze riguardanti il regolamento e buon' ordine del Conservatorio di S. Spirito. In Roma MDCCCVI' (hereafter *cit.* NSVP), p. 73.

[19] *Ibidem.*

[20] n. 1305, 'Edictum pro Conservatorio Puellarum S. Spiritus 1716'; n. 1305, 'Antonio Maria Pallavicini Arcivescovo di Lepanto e Commendatore del Sacro Apostolico Archiospedale di S. Spirito in Sassia 1739'.

[21] n. 1305, 'Stato della Casa... di Monsignor Spada, 1661', p. 6.

[22] On religious life in the Conservatory see M. Surdacki, 'La vita religiosa', pp. 149-165.

[23] Biblioteca Apostolica Vaticana, Barberino Latino 10683 (ff. 2-29v), cap. 2. 'Relatione del modo, che si tiene da Religiosi di Santo Spirito in Sassia di Roma nel governo dell'archiospedale apostolico di Santo Spirito, e dell'ordine, che si osserva nella cura degl'infirmi, et esposti, scritta da fra Domenico Borgarucci religioso, et secretario del medesimo Ordine'.

[24] *Ibidem.*, cap. 3.

[25] The details and comments on the procedure by which children were abandoned at the 'ruota' of the hospital of the Holy Spirit and how these childern were taken care of are to be found in the article: M. Surdacki, 'Dzieci porzucone w Rzymie', *Roczniki Humanistyczne*, 22, 1994, z. 2, pp. 84-108.

[26] For the wet-nurses who raised the 'abandoned children' see C. Schiavoni, 'Le balie del brefotrofio dell'ospedale di Santo Spirito in Saxia di Roma '500 e '800', *Archivi e Cultura, Nuova Serie*, XXV-XXVI, pp. 177-242. See also M. Surdacki, 'Dzieci porzucone w Rzymie', pp. 98-104.

[27] Vedi M. Surdacki, 'Dzieci porzucone w Rzymie', pp. 98-99.

[28] n. 1305, 'Ordini per dentro il Monastero 1660', in NSVP, p. 4. See alsp n. 1414B, 'Stato dell'officii...', pp. 41-42; n. 1305, 'Regolamento delle Zitelle del Conservatorio del Monsig. Pallavicini Commendatore 1748. Regole che devono osservarsi nel Conservatorio del Sagro Apostolico Archiospedale di S. Spirito in Sassia di Roma'.

[29] n. 1305, 'Ordini per dentro il Monastero 1660'.

[30] n. 1305, manuscript entitled 'Clemens XI. P.O.M.'.

[31] n. 61, 'Giornale. Memorie delle Cose più Notabili accadute circa gli Affari del Ven. Archiospedale di S. Spirito da 28 luglio 1758, sino a 28 dicembre 1758', p. 15.

[32] n. 1305, manuscript entitled 'Clemens XI. P.O.M.'.

[33] n. 1305, 'Decreti di Visita...1679', p. 73.

[34] n. 1305, 'Questo è il modo del vivere, e governare, che fanno le Monache, e le Zitelle sue di S. Spirito in Sassia di Roma indigentissime Serve e Suddite etc. 1660', pp. 21-22.

[35] n. 1305, 'Editto a tutti i Ministri del Conservatorio Nuovo 1662', inNSVP, p. 45; n. 1305, 'Officio della Priora del Conservatorio 1661'.

[36] n. 1305, 'Ordini della Sagra Visita di non entrare nel Coservatorio, di non lavare, e sopra il vestire, inferme, medico, portinare, ascoltatrici, confessore ed altro 1808', p. 217; n. 1305, 'Ordini per il Conservatorio di S. Spirito. Giovanni Battista Spinola Commendatore 1688', in NSVP, p. 78.

[37] n. 1305, manuscript entitled 'Clemens XI. P.O.M.'.

[38] n. 1305, 'Stato della Casa... di Monsignor Spada, 1661', pp. 6-7.

[39] n. 1305, 'Regolamenti che si pratticano... 1754'.

[40] C. Schiavoni, 'Gli infanti', pp. 1039-1040.

[41] n. 12bis, 'Ordini di Monsig. Gio. Btta. Ruini Commendatore dell'Apostolico Hospitale di Santo Spirito di Roma pubblicati sotto il di 1587'.

[42] n. 1305, 'Stato della Casa... di Monsignor Spada, 1661', p. 6; n. 1305, 'Visita de Proietti ed utili 1740' ("...per il grande affetto che li portano verso dette per averle allevate" ('because of the great affection they feel for them because they have brought them up'); n. 1414B, 'Stato dell'officij...', p. 13 ("per carità e buon affetto, che portano verso questi poveri proietti se li pigliano per figli adottivi" ('because of the charity and good affection they feel for these poor foundlings they take them as their adopted children').

[43] n. 1305, 'Stato della Casa... di Monsignor Spada, 1661', pp. 8-9.

[44] n. 1305, 'Visita de Proietti ed utili 1740'.

[45] n. 1305, 'Regolamenti che si praticano... 1754'.

[46] n. 1305, 'Concessione a tempo nubile delle Proiette fatta dall'Archiospedale e Pia casa di Santo Spirito in Sassia. Questo è il modulo che si compilava al momento della concessione'.

[47] M. Surdacki, *Dzieci porzucone w Szpitalu*, pp. 358-360.

[48] *Ibidem*, pp. 360-362.

[49] These data are taken from tables 8 and 9 in M. Surdacki, *Dzieci porzucone w Szpitalu*, pp. 360, 364.

[50] n. 1305, 'Decreti di Visita...1679', p. 79.

[51] M. Surdacki, *Dzieci porzucone w Szpitalu*, pp. 373-396, *idem*, 'Marriages', pp. 99-122.

The Department of Pastoral Care at the Cardinal Tien Hospital in Taiwan

1. The Beginning of the Establishment

As a tradition, when the Catholic Church is considering building a hospital, she usually looks at where there is a lack of good medical service in the poorer section of town. The Church in caring for the people is concerned not only about the cure of the body, but even more about the needs of the mind (heart) and soul (spirit). Therefore, from the outset, a Chaplain was assigned to administer the sacraments to the sick. The rest of the priests, sisters and lay Catholics on the staff served the patients in various capacities but with a pastoral care perspective.

In the early part of 1990, with the expansion of the Cardinal Tien Hospital, Sister Mary Ann Lou SDSH, Director of the Hospital, responded to the needs of the time. She initiated a pastoral care unit as an independent department. In this way the pastoral care ministry was officially begun by a full time staff trained for such services. The Pastoral Care Department began with the priest Chaplain and one pastoral care giver, now we are staffed by one Chaplain 24 hours on call, one supervisor, 6 full time, 2 part time pastoral care givers and one clerk.

2. Mission and Objectives

To communicate Christian love/good news to all the patients, their family members and to all the hospital staff through the Pastoral Care Ministry in the forms of: caring, being present, listening, and providing guidance.

3. Role and Functions

The pastoral care givers:

1. Endeavor to build up mutual trust with the patients, and their families, and to develop a friendly atmosphere in order to assess their spiritual as well as other emotional or temporal needs.

2. Provide religious and spiritual services to Catholics, and spiritual assistance to non-Catholics whose practices differ from our own.

3. Act as a bridge of communication and good will between:

A. Patients and their family members.

B. Patients and other staff members.

C. Among the staff members themselves.

4. Responsibility of the Pastoral Care Givers

1. Services provided for/to the hospital staff:

A. Psycho-spiritual assistance: Offering support to the staff in their work, through attentive listening, counseling and acceptance of complaints.

B. Education: Participation in planning and executing:

a. Staff orientation to the hospital's mission of charity and service.

b. An introduction to the Pastoral Care Department as a part of new-employees' training program.

c. Provide spiritual seminars and seminars for those interested in knowing more about Catholicism.

d. Instructions in Catechism by offering the Rite for the Christian Initiation of Adults and preparation for First Holy Communion, classes are offered to employees and their family.

e. Classes in self-understanding and better communication among family members are also offered for the hospital staff.

f. Participation in "Grief Counseling" series by those staff in need.

C. Liturgy – To promote evangelization.

a. Conducting weekly morning or noon prayer/group, meetings, in the various departments of the hospital.

b. Adoration of the Blessed Sacrament (Holy Hour) in the Chapel every Friday.

c. Advent and Lenten Days of Recollection for the Catholic and interested members of the staff.

d. Feast day celebrations

Christmas: 1) Procession, Holy Mass, shared meals. (agape)

2) Carolling and choir contest to encourage learning of Christmas songs.

3) Christmas decoration contest for all nursing stations, to promote understanding of and love for Christmas.

Easter and Pentecost: Special liturgy for the staff, e.g. Pass-over Agape, egg painting, contest and exhibition.

Chinese New Year: Ceremonial expression of worship to God, honor to ancestors, goodwill to each other, as a bridge between Christian and local customs.

e. Planning and executing of the liturgical ceremony for the

blessing of every new area or service of the hospital at its formal opening.

D. Activities:

a. Assisting the employees' "Christian life community" weekly gathering in order to give them a better sense of belonging and spiritual growth.

b. Managing the annual assembly of Catholic health care professionals (hospital administrators, physicians, nurses, etc.)

c. Providing a religious atmosphere in the hospital through art and music so that patients and staff may feel the warmth of a Christian environment.

2. Services given to patients: Include the following areas of concerns:

A. To visit new patients: To listen and to comfort by empathic listening and making referrals to related resource persons. Special attention is given to patients with cancer, major surgery, suicide, assault etc. major emotional issues.

B. To offer spiritual services of Mass, Holy Communion, Baptism, Reconciliation and Anointing.

C. To offer to those patients with long term hospital stay support and comfort, including their family members in their needs. When occasions arise, attempts are also made to explore the meaning of life and of suffering, sharing with them the good news of the Gospel.

D. For the family members of dying patients or patients suffering from fatal accidents, the pastoral care givers' presence is very important to comfort them and to assist the family to carry out a Christian burial service. Bereavement care is also provided whenever needed.

E. Whenever the patients present a financial need, referrals are made to the Social Service Department for appropriate allocation of funding. The Pastoral Care Department offers a small scale Pastoral Care Fund for patients' current use, such as clothing, food, nutrition, even short term subsidies for the family, so that the patients can have a relatively peaceful hospital stay during the crisis.

F. To provide books, articles, pamphlets of a spiritual nature for patients and family members to read.

G. To assist priests and religious in the processes of hospital admission and discharge.

H. To plan liturgical celebration of World Health Day for patients and their families.

I. To participate in case conferences in hospital wards.

J. To plan basic training program for the volunteers in patient visitation.

K. Foreign laborers who come to Cardinal Tien Hospital for the required pre-employment physical examination are also our concern. Religious articles, spiritual books, directory of Churches near their work places etc. are prepared for their use.

L. Net working with Pastoral Care Givers of other Catholic and Protestant Health Care Institutions: exchanging ideas, giving mutual support, encouraging the upgrading of quality of services.

5. Others

1. Attending to the needs of "Community Health" programs, e.g. the Evergreen Senior Citizen Group, in their spiritual well being.
2. Regularly contributing spiritual articles and reports of enriching experiences to the hospital's monthly newsletter.

6. Plans for the Future

1. To reinforce the spiritual growth and renewal of the hospital staff.
2. To strengthen and work towards an ever more harmonized team work among the medical and para-medical staff, so that the Christian spirit be further manifested.
3. To up grade the professional quality of our Pastoral Care givers: to prepare teachers and provide a training center for this country's future Hospital Pastoral Care Givers.

Archdiocese of Philadelphia: Protocol for Evaluating Catholic Health Care Collaborative Relationships

Due to the complex nature of health care, some Catholic health care providers have determined that in order to preserve their ministry, there is a pressing need for joint ventures, partnerships or other types of collaborative relationships relevant to the joint financing and the joint delivery of health care a (hereinafter referred to as "Collaborative Relationships"). It is understood that in such Collaborative Relationships, Catholic health care providers operating in the Archdiocese of Philadelphia will give priority to entering into relationships with other Catholic health care institutions and agencies in order that the Catholic presence in the provision of health care might remain strong and influential, witnessing collectively to their shared ministry.

If it is determined that no exclusively Catholic relationship is possible and a Collaborative Relationship with a non-Catholic provider is proposed, the Catholic health care provider must evaluate the proposed Collaborative Relationship in light of each of the following:

1. the necessity of strengthening the Catholic health care apostolate within the Archdiocese;

2. the future viability of the particular Catholic health care provider as well as the future possible harm to the particular Catholic health care provider if it did not enter into the Collaborative Relationship;

3. the need for pro-active advocacy on behalf of Catholic ethical and moral principles;

4. the necessity of avoiding formal cooperation in evil;

5. the necessity to avoid public scandal; and,

6. the necessity to educate the community regarding the Collaborative Relationship.

Catholic health care providers shall not enter into any major alliance or affiliation agreement with non-Catholic health care providers without the *nihil obstat* of the Archbishop of Philadelphia. For subsequent "collaborative relationship" flowing from the major alliance or affiliation agreement, a petition for a *nihil obstat* needs to be made only when the Secretary for Catholic Human Services is reasonably concerned that the "collaborative relationship" might negatively affect the mission or religious or ethical identity of such Catholic health care providers. The Archbishop will specify a process for the review of such ventures in consultation with all relevant parties. Because of the necessity for the Archdiocese to be apprised at the onset, such Collaborative Relationships are to be presented in writing to the Archdiocese of Philadelphia before any substantial negotiations are undertaken with the prospective partners. The Collaborative Relationship will be evaluated in light of Church teaching and canonical legislation, the proper law of the Sponsors, the necessity of the relationship and the likely effect that the activity will have on other apostolates within the Archdiocese.

The Archbishop or his delegate will use the following criteria among others in evaluating these relationships.

1. Collaborative Relationships shall enhance the local Catholic health care apostolate by:

a) helping to implement the Church's moral and social teaching;

b) furthering the health care ministry to the community;

c) witnessing to a responsible stewardship of limited health care resources;

d) providing poor and vulnerable persons with a more equitable access to basic health care.

2. All activities arising from the Collaborative Relationship will conform to the "Ethical and Religious Directives for Catholic Health Care Services";

3. Catholic providers will only enter into Collaborative Relationships that do not violate the principles of cooperation with evil regarding procedures judged to be immoral by the Catholic Church, for example as stated in the *Ethical and Religious Directives for Catholic Health Care Services* as they currently exist or are amended in the future.

4. A Catholic provider cannot own or manage an institution that by policy or practice engages in intrinsically immoral activities.

5. A *nihil obstat* will not be granted to Collaborative Relationships in which the result will be that the Catholic health care provider becomes a publicly traded, investor owned, for-profit entity so as to lose its not-for-profit status.

Procedure for evaluating Catholic health care collaborative realtionships

PURPOSE:

1. To preserve the Catholic identity and ensure the continuation of the mission of health care apostolates operating within the Archdiocese of Philadelphia;

2. To promote cooperation of all parties involved in the Catholic health care apostolate in the Archdiocese of Philadelphia; and,

3. To further the healing ministry that embodies the Gospel message of Jesus Christ as reflected in the values and teachings of the Catholic Church and in the *Ethical and Religious Directives for Catholic Health Care Services.*

SCOPE:

In compliance with particular law of the Archdiocese of Philadelphia, promulgated February 25, 1999 and effective as of March 25, 1999, all Catholic health care providers operating in the Archdiocese are obligated to follow these procedures.

POLICY:

1. The Archbishop of Philadelphia shall establish the Catholic Health Care Review Committee ("Committee").

2. This Committee will review all proposed Collaborative Relationships with non-Catholic providers which would result in a major alliance or affiliation and thereby require the *nihil obstat* of the Archbishop of Philadelphia. For subsequent collaborative relationships flowing from the major alliance or affiliation agreement, or other collaborative relationships of a less substantive nature, review by the Committee will only occur upon recommendation from the Secretary for Catholic Human Services.

3. The Committee will provide a recommendation to the Archbishop of Philadelphia regarding the appropriateness of such Collaborative Relationships based on the criteria defined in the relevant particular law.

4. The Committee will consist of the Secretary for Catholic Human Services of the Archdiocese of Philadelphia (who will serve as chair), no more than three (3) priests, one member of a religious congregation and one Catholic lay person, all of whom will have some expertise in Catholic health care issues.

5. The members of the Committee shall be appointed to serve for a term of three (3) years, which may be renewed once.

6. The Archbishop shall appoint all the members of the committee.

7. The committee will have the opportunity for consultation with individuals or appropriate, recognized groups with the requisite expertise in civil law, canon law, moral theology and health care.

PROCEDURE:

The procedure for the evaluation of Collaborative Relationships which affect the mission or religious and ethical identity of Catholic health care providers is as follows:

1. Because of the necessity for the Archdiocese to be apprised at the onset, the health care provider will notify in writing the Secretary for Catholic Human Services of the potential for a such a Collaborative Relationship before any substantial negotiations are undertaken with the prospective partner. In consultation with the Catholic health care provider, the Secretary will either monitor the proposal, ask for additional information or refer the proposal to the Committee. Prior to the submission of any proposal to the Committee, the Secretary will work with the Catholic health care provider to assure that the draft which is to be reviewed reflects all changes which have been recommended by the appropriate consultants.

2. In collaboration with the Catholic health care provider proposing the Collaborative Relationship the Committee will determine the time line necessary for submission to the Archbishop for his consideration. While it is understood that the Committee will always be sensitive to the time constraints of the Catholic health care provider, it is likewise noted that the Committee itself will require adequate time to read and evaluate the documents submitted to it.

3. The Committee will determine the extent of the review based on the significance and nature of the matter.

4. Upon completion of its review, the committee will submit its report and a recommendation to the Archbishop for his consideration.

5. All Committee discussions, meetings, correspondence and recommendations to the Archbishop are to be maintained in the strictest confidence.

6. The Procedure will be reviewed after three years. The Secretary for Catholic Human Services will initiate this review.

The Paulinian Approach to Nursing Education: A Response to the Church's Call for Compassionate Caring

Introduction

In the light of the present societal condition where the nursing profession is being threatened by the dehumanization of health care, the formation, strengthening, and deepening of the carative character of nursing is of prime importance. Formation is essentially the task of education, and education, to be authentic and wholistic, has to address itself to the whole person. This paper, undertaken by those who are involved in the formation of Paulinian nurses, has helped the writer to scientifically validate the efficacy of the process of the Paulinian training, and to assess and see what area in the approach to Paulinian Nursing Education impacts on the life and professional practice of the students and graduates. It has also enabled us to correct weaknesses, clarify ambiguities, strengthen positive aspects, revise/enrich the curriculum, and adopt proper measures to further enhance the carative quality and standard of excellence of our nursing education.

The St. Paul College of Iloilo

The formation of Care Givers, particularly Catholic nurses, has always been in the forefront of the apostolic work of the Sisters of St Paul of Chartres. In the Philippines, this evangelizing activity formally began in 1946, when the St Paul School of Nursing in Iloilo was established. Primarily, the purpose for opening the school was to meet the need for trained Catholic professional nurses who could minister to the patients of St Paul Hospital, the only Catholic hospital in the region. In a way, the move was also a response of the Church to the challenge laid by the burgeoning Protestant Mission School of Nursing of the Central Philippine University. It was the call of the time to prepare lay Catholic nurses to carry on the caring ministry of the Church.

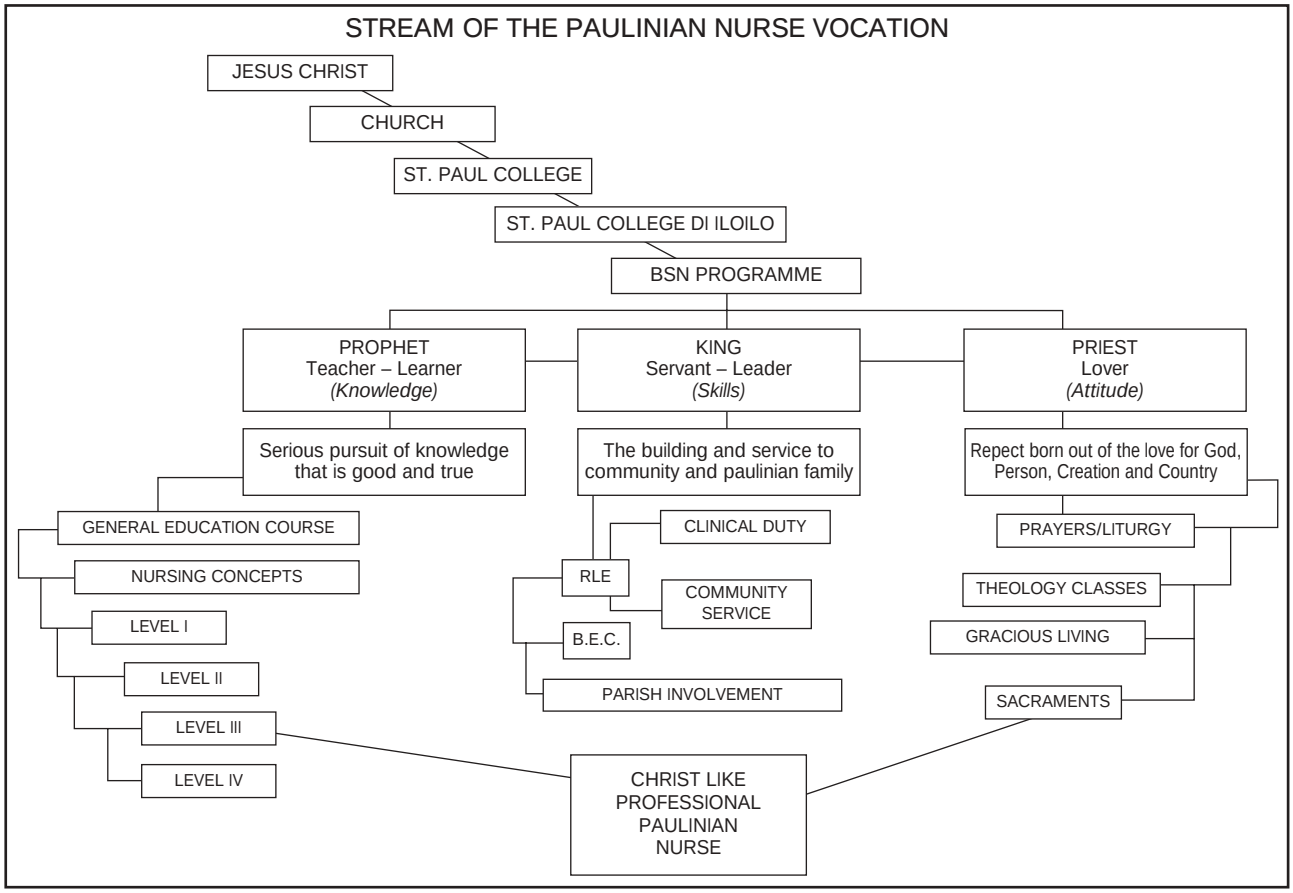
From its inception, the orientation of the school was wholistic; its focus, Christic. It aimed at preparing nurses who would care not only for the physical and medical needs of the patients, but also for the spiritual and moral aspect of the patients illnesses as well – nurses who would bring Christ to the sick. To attain this goal a program of study that would promote the enhancement and development of the gospel caring values, as much as academic excellence and professional competence, has always been utilized by the school as its tool. All through its existence, the needs of the times, the advent of innovative educational strategies, and technological progress, have always been considerations for constant adaptation, but the program's basic approach and core values for the last 50 years have remained constant. The conceptual model of the program is known to both faculty and students as the *stream of the professional paulinian nurse vocation.*

The Paulinian nursing education framework

The educational framework of the Paulinian Approach to Nursing is Christocentric. This has been so from the beginning of its foundation. The graphical presentation of the model is titled the *stream of the professional paulinian nurse vocation* [SPPNV]. It is called a *stream* because, like the gentle flowing body of water we call a stream, the Paulinian nurse's calling is rooted and sourced in Christ, and flows from Him. It is active, life giving, and dynamic... flowing from Jesus, given to the Church, shared by the Congregation of the Sisters of St. Paul of Chartres, commissioned to the College of St. Paul, and made actual in the Bachelor of Science in Nursing Program. It is *professional* because it is an organized, integrated, and systematic discipline, with its own set of objectives, goals, rules, standards, practices, and activities, the performances of which entitles the person to receive a commensurate remuneration. Its process is clearly understood and appreciated by all concerned and has been passed on from generation to generation, not only in the classroom, but also through the witness and example of its graduates. The term *paulinian* is the benchmark of the training. This identifies the nurse as a member of a particular group or family, formed according to a specific approach, upholding a particular tradition and believing in the same ideal in life. The term *nurse* defines and particularizes the discipline of the educational program. The students are trained to become nurses – not midwives, not doctors, not therapists, not pharmacists, not physical therapists, not any other health professionals, but nurses. And finally, theirs is not only a profession, an occupation that shall be their source of income but, most of all, a *vocation*, A RESPONSE TO A CALL, the call to follow Christ-Prophet, King and Priest, the Health Care Giver *par excellence.* This is clear to all Paulinians and is deeply ingrained in their hearts, especially the older graduates, who have had the fortune to be taught

by the nuns themselves.

What is this *Stream*, this approach, this theoretical framework of the Paulinian Nursing Education?



The Paulinian nurse rooted in Christ

The Paulinian Nurse is Rooted in Christ – ***Christ Prophet (teacher), Christ King, (servant-leader), Christ Priest (lover)***. Inspired by and following the footsteps of Jesus, the Paulinian nurses are to become, in their turn, teacher-learners, servant-leaders, and loving caregivers; caregivers who are knowledgeable, competent, compassionate. These qualities, values to be acquired, are ingrained and developed in the educand's mind, hand, and heart via the three fold aspects or components of the teaching-learning process: the cognitive, the psycho-motor, and the affective or attitudinal components. In the context of the Paulinian Nursing Program of study, these are seen in terms of Knowledge (Teacher – Learner), Skills (Servant – Leader), and Attitude (Lover).

Teacher-Learner [Knowledge] – The cognitive component is aimed at the development of the mind or the intellect of the Paulinian nurse. Engendered through general education and professional nursing subjects, this is nurtured in an institutional culture that values serious pursuit for knowledge that is good, beautiful, and true. The general education subjects, consisting of courses in social, natural and practical sciences, philosophy, language, arts and humanities, broaden the horizon of the students. The professional subjects equip them with the knowledge of nursing concepts, principles, theories and practice. The students are exposed to various philosophies, intellectual persuasions, and secular subjects and orientations, but the Christian message and perspective are brought out to them. In other words, they are taught to uncover the Gospel values that are at the ground of all cultures and of science, and to enrich with the Gospel truth and values their secular learning – in the words of the Holy Father, "to unify culture and faith, gospel with life". This integration of scientific knowledge and faith is even more explicit in the treatment of the professional nursing subjects. Here, the wholistic approach is demonstrated with the symbol of the Eucharist, with each nursing year-level subject requirement representing a segment of the Host.

Servant-Leader [Skills] – The second component of the program refers to the skills or psycho-motor development portion of the Stream. This aspect is focused on the application of the knowledge gained in theory, on acquiring the competency expected for the level and the living out of the Christian notion of leadership as service. Of utmost importance in this portion is enabling the student to apply the work ethics they are taught in the classroom, and to witness

in their day-to-day activities their Christian commitment to serve like Christ. This is carried out in the Related Learning Experience activities in the clinical area and the community setting, and in their involvement in the parish activities through the Campus Ministry Program. To inculcate the value, they are immersed in an institutional culture which promotes "the building of and services to the community and the Christian family". The current global shift of the health care services from the institution to the community in a very real sense dovetails with the Paulinian approach to community service. In fact, in the 1980's the College of Nursing was chosen by the Department of Nursing Education to be the pilot school for the new curriculum which required intensive student community immersion. Today, once again, the Paulinian Colleges of Nursing are spear-heading the new Health Resource Development Program Community Organizing Participatory Action Research [HRDP–COPAR] approach to Primary Health Care.

LOVER [Attitude/Affective] – The third component directly pertains to the heart. It most directly touches the core of Paulinian Education. Without minimizing the importance of knowledge and skill components, the students are made aware of the primacy of this dimension in their education. Christian value formation and transformation is impressed on them as that which makes their training different, that which sets them apart from other nurses. When the ***Stream*** is explained to them for the first time, the students are thrilled to learn that they are to become ***Lovers*** – compassionate, humane, gentle, warm, tender lovers like Christ.

Of the three components of learning this dimension in the Paulinian educative process, this is the one most in need of being stressed today. This is because the students who come to us at this point in time are "children of the media" whose values, more often than not, are shaped by this "very powerful teacher". It is unnecessary to detail how the values of the "world" are directly in opposition to the Gospel value of loving service and of caring. To help, therefore, bring about the desired attitudinal change in the student, the school promotes a vibrant Christian Formation Program. This consists of an integrated course in Religious Education and Gracious Living, the regular celebration of the Liturgy and the Sacraments, provision for spiritual retreats and times for prayer, guidance and counseling, and in patiently allowing the students to express themselves and "to become" in an existential experience of life. All these in an environment of respect that is born out of love for God, persons, creation, and country, and in truly loving them.

THE PRESENT

Clearly, the Paulinian Approach to Nursing Education is undertaken within the context of the Sisters of St. Paul of Chartres's mission. The fact that ours is a Christian Country and that 95% of our students are Catholics, is the one great factor that enables us and facilitates the anchoring of our program of study in the Christian tenets of knowing, serving and loving God in the sick; of seeing Christ in the client and of being Christ to them. In a nutshell, Paulinian Nursing Education hopes and strives to form Catholic professional, competent nurses who, with the Blessed Mother as their model, and inspired by St. Paul their patron, think with the mind of Christ, serve with the hand of Christ, and love with the heart of Christ. Admittedly, this is a very ambitious goal; but, always reminded by the proverbial Gospel "seed" and the various kinds of "soil", and trusting in God, the Paulinians forge on with their motto, "Caritas Christi Urget Nos".

"You will know the tree by its fruit". The effectiveness of an educational approach is generally measured by the performance of its graduates. On the academic plane, an assuring confirmation of the efficacy of the Paulinian Approach is the track record of its graduates performance in the National Nurses Licensure Examination. Since 1948, the school has always been among the Ten Outstanding Schools/Colleges of Nursing in the country recognized by the Philippine Government Professional Regulation Commission Board of Nursing and the Commission on Higher Education. It is also among the few colleges of

nursing deputized by the same Commission to implement its Expanded Tertiary Education Accreditation Program.

Within the last 50 years, St. Paul College has graduated thousands of professional nurses who are now scattered in many countries. Quite a number have made their mark in their places of work, recognized not only for their competence but also for their Christian professionalism. Some have been recipients of prestigious awards, such as the Legion of Honor of France and the Posthumous Award of Recognition for Dedication to Duty. Mostly, they work as missionaries, educators, administrators, practitioners, clinicians, community health workers, volunteers, nurse entrepreneurs or simply parenting their children, quietly spreading the Good News of Christ through their caring ministry.

The small nursing school offering the Graduate Nurse Certificate Program is now a college offering not only the Nursing Baccalaureate degree and a Graduate School Nursing Program, but other courses as well. Also, there are now four Paulinian Colleges of Nursing in the Philippines.

Yet another affirmation of this approach is the support from grateful parents that the school receives, parents who believe in the quality of education that the school offers, and therefore continually entrust the formation of their children to the college. But perhaps the most satisfying assurances are the testimonies of the graduates themselves, whose lives are marked by the mark of Christ, their coat-of-arms, "Caritas Christi Urget Nos! Once a Paulinian, always a Paulinian!".

THE FUTURE

As it faces the coming of the third millennium today, what are the challenges, the obstacles the college is facing? First of all, there is the loss of appreciation of the youth for the service profes-

sions which do not bring in cash, coupled with the high cost of nursing education. This is evident in the Philippines. As previously pointed out, the youth of today are very much influenced by the culture of the mass media which extolls materialism and consumerism as a way of life. Success is equated with having more, with what is big being beautiful. Also, due to the closure of the foreign employment market on the one hand, and the economic difficulty prevailing in the country on the other, there has been a marked decrease of enrollment in the course. This has serious repercussions. Many schools have had to retrench; others have had to close. Nursing employment opportunities are affected, faculty have had to be deloaded or their employment terminated.

Another challenge that has to be met, in our country, at least, is the political passivity of our nurses. Because, historically, Filipino nurses were trained and made to believe that they were handmaidens of the physicians, many Filipino nurses have remained the passive silent majority. Uninformed or unconcerned with many social and/or political issues, legislation prejudicial to their welfare is passed and becomes law without their knowing about it. An example of this is the provision in the Philippine Nursing Law which regulates the eligibility of entrance to the Nursing School to the upper 40% of high school graduates. While the intent of the law is good, its application is prejudicial, both to the prospective student and the Colleges of Nursing. Nursing education must, therefore, provide opportunities to develop Christian assertiveness among students, so that they may be able to stand for a just cause with serenity and courage.

A third and most exciting challenge is the globalization of the third millennium. Nursing must make the quantum leap or perish as a profession. Considering the pace at which societal changes are taking place today, nursing cannot afford to stand still and live in the glory of its past. It must adjust, adapt, and change, be in step with progress in science and technology. As some modern psychologists put it, it should be like a dolphin, able to gracefully ride the crest of the waves of change. However, in this quest for progress and amidst the whirling rapidity of societal and cultural change, nursing must never forget its essence of caring and loving service. Maintaining this balance is the challenge that all nursing educators share today.

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