DOLENTIUM HOMINUM

N. 48 — Year XVI — No. 3, 2001

JOURNAL OF THE PONTIFICAL COUNCIL
FOR HEALTH PASTORAL CARE

Editorial and Business Offices: PONTIFICAL COUNCIL FOR HEALTH PASTORAL CARE
VATICAN CITY; Tel. 06-6988-3138, 06-6988-4720, 06-6988-4799,
Fax: 06-6988-3139 - www.healthpastoral.org - E-MAIL: opersanit@hlthwork.va

Published three times a year. Subscription rate: Lire 60.000 (or the equivalent in local currency), postage included

Printed by Editrice VELAR S.p.A., Gorle (BG)

Cover: Glass window Rev. Costantino Ruggeri

Spedizione in a.p. - art. 2, comma 20/c, legge 662/96 - Roma

Contents

The illustrations in this edition are taken from the book:
'Omaggio a San Marco, Tesori dall'Europa'
edited by Hermann Fillitz, Giovanni Morello
Electa

Prayer to Mary Most Holy «Health of the Sick»

O Virgin Mary, «Health of the sick»,
you who accompanied Jesus on the way to Calvary
and remained near the cross on which your Son died,
participating intimately in his suffering,
take our suffering and unite them with His,
so that the seeds sown during the Jubilee
continue to produce abundant fruits in the coming years.
Most tender Mother, we turn to you with confidence.
Obtain from your Son the strength to return soon,
completely restored, to our duties,
so that we be useful to our neighbour through our work.

Meanwhile stay with us at the moment of trial
and help us to repeat everyday with you our yes,
sure that God will bring out from every evil a greater goodness.
Immaculate Virgin, may the fruits of the Jubilee Year
be for us and for our dear ones
a pledge of renewed vigour in Christian life,
so that in the contemplation of the Face of the Risen Christ
we will find the abundance of the mercy of God
and the joy of a more complete union with the brethren,
the beginning of the joy without end in heaven. Amen.

Vatican City, February 11, 2001.

Pontifical Appointments

The Holy Father has confirmed, for another quinquenium,
His Excellency Msgr. Javier Lozano Barragán
President of the Pontifical Council for Health Pastoral Care

The Holy Father has confirmed, for another quinquenium,
His Excellency Msgr. José Luis Redrado Marchite, O.H.
Secretary of the same Pontifical Council

The Holy Father has confirmed
Reverend Father Felice Ruffini, M.I.
Under-Secretary of the same Pontifical Council, until the age of 70.

Topics

The Perception of Pain in the Buddhist World

Evangelisation in the World of Mental Health: Foundations and Guidelines for Action

The Anthropology and Ethics of Dying

Dying in our Society: Philosophical and Ethical Aspects

The Perception of Pain in the Buddhist World

In order to introduce the subject of our meeting I would like to make an observation which is perhaps obvious but which is nonetheless also essential: in the generally accepted meaning of the term,"pain" is something which is experienced at various levels by all human beings without any distinction. The perception of pain and individual and collective responses to it, on the other hand, vary from person to person and from people to people. Indeed, it is because of this fact that reference is rightly made to an anthropology of pain. Employing the reflections of philosophers on this term, I would say that pain is that which is most specific, individual and non-transferable in the lives of men. At the same time, however, because it involves an experience which inevitable leads the person who suffers to ask himself why he and not others is afflicted by such pain, pain itself becomes a subject of thought and attention and leads the person who suffers from it to speak about his own pain and thereby to escape the prison of loneliness to which pain – because of its intrinsic nature – has condemned him. Within testimony to pain the individual and collective meaning of suffering are bound up in an inseparable way. This is because the person who speaks about his own pain speaks about it in a world in which mental and oral categories already exist, and these categories, it should be observed, are designed to be understood by other people. The universal dimension is present in every individual experience of pain and allows the individual who suffers to communicate that pain in a scenario which already exists. These are scenarios of meaning which make suffering more bearable and tolerable because within them pain is justified and understood.

This is true for all men, whether they are children of Western culture or Eastern cultures. Throughout history mankind has been tested by the experience of pain and has interacted with it and tried to find different answers to it. But these answers are always sought through a vision of pain which sees it as a time of trial and judgement which involves the entire meaning of personal existence.

The literature on this subject is very great. Here it is sufficient, for the purposes of understanding the questions and issues which are being addressed, to cite, for example, the opinions of the philosopher Salvatore Natoli. In the opinion of this authority there are in essential terms two great cultural forms through which the West has interpreted suffering – on the one hand the tradition of the Greek world which was characterised by the meaning of tragedy from which there sprang the vision of the hero who challenged pain; and on the other the Judeo-Christian tradition which affirms that man must resist pain and await salvation. In the contemporary world, observes Natoli, these ideal visions have been replaced by faith in technology and science. The approach which sees technical instruments as offering the solution to pain and which concentrates solely on the sick part of the suffering person is an approach which is typical of Western society, and this occurs as that society becomes ever more distant from its religious roots.

In this way pain tends to be removed and to be withdrawn from sight and handed over to professionals. At times it is even denied. The context within which science and technology operate is based upon the idea of dominating and eliminating pain. Thanks to the opportunities offered by modern therapeutic techniques, science and technology have the ability to cross the threshold of pain and thus to decide the levels of perception of suffering. Following to the utmost the idea of control over pain there is even the idea that in the future the world will be pain-free – in this way technology will be able to give us what God has denied us. In ancient times it was not possible to alter the natural path taken by men but in the contemporary world this is no longer the case.

I would like to make it absolutely clear that I do not in any way wish to diminish the great benevolent effects of the high scientific levels which have been attained by Western medicine. Instead, I want to identify the reasons why many people now ask themselves about the actual real value of an answer to pain which is based exclusively on a faith in technological and scientific means and instruments.

It is in this sense no accident that I have been invited to speak here today, and my presence is certainly not the outcome of the fact that Buddhism or Tibet have become fashionable. It is because, rather, that in people who are more sensitive towards, and concerned with, the questions and issues connected with pain there is a growing interest in possible alternatives which can interact with modern technology and methods to help those who suffer and are in pain, something which is matched by increased interest in the cultural world from which these alternatives come.

In speaking about the perception of pain within the Buddhist world I am compelled to engage in a clarification which brings out with greater precision what is actually meant by the phrase "Buddhist world".

Buddhism is a religion which has experienced twenty-five centuries of history and which began in India roughly speaking in the fifth century before Christ. It then spread throughout Asia and changed its shape and form according to its geographical location. These changes were possible because Buddhism did not preach theological principles but proposed instead the superiority of practice over theory and left people from different cultures and traditions to encounter each other at the level of experience. It will suffice for my purposes in this paper to dwell upon the

core of the oldest preaching of the historical Buddha which is made up of the so called "Four Noble Truths". These are the basis of the various schools and currents of Buddhism. An analysis of these "Four Noble Truths" enables us to understand immediately how pain is seen in this religion as being central to existence. The order in which the Buddha (who is also called the "physician of all peoples") lists his truths reminds us of the diagnostic *schema* of ancient Indian medicine, and this of course is not a question of mere chance. This branch of medicine believed that it was first necessary to identify the malady and its symptoms, then to discover whether it could be cured, and finally to prescribe the treatment which was required to heal the patient.

Taking this approach as a model, in the Buddhist way of thinking the malady is akin to existential pain and suffering. The first noble truth asserts that everything is pain. The second noble truth discerns in desire and in attachment to existence the real cause of the malady. The third noble truth sees the suppression or the ending of desire as the cure for the maladies of existence. Lastly, with reference to the prescription which is needed to obtain healing, the fourth noble virtue points to the path which leads to the ending of desire and thus to the elimination of pain and suffering.

This path involves a detailed ascetic practice termed "Noble Eightfold Path" whose initial and fundamental base is the regulation and ordering of the individual's life in line with certain sound moral principles (the person should not kill, steal, lie, or commit adultery, etc.). I would like to observe here that Buddhism has also been defined as being an ethical philosophy.

In Buddhist thought, it should be observed, the distinction between pain and pains is very important. Pain is immediately perceivable and experienced by everybody, even though it is limited to certain events such as illness, old age, death and the more subtle and universal suffering caused by all possible changes.

If a person follows the path indicated by the Noble Eightfold Path in his behaviour – which is seen by the Buddhists as being physical, vocal and mental in character (that is to say a person behaves well or badly with his body, his speech and his mind) – then he will not be moved by the three negative impulses of hatred, greed and ignorance and will not be responsible for negative consequences. On the contrary, he will generate compassion for all living creatures and this feeling produces in those who experience it a great desire to achieve salvation or illumination. For Buddhists, our acts follow us in this world and the world to come, and for this reason the great goal is to escape a convulsive way of living, stop moving, and enjoy the peace of liberation – liberation from the cycle of birth and death in order to achieve Nirvana, an indescribable state of being.

When I refer to the Buddhist world I mean the whole of that cultural world which identifies its vision of faith and life "more or less" with the principles which I have just outlined above. Buddhism, therefore, sees the whole of human existence as being inseparably bound up with pain. In a similar approach, illness, old age and death are accepted as being inescapable in the same way as pain is inescapable. This, however, does not in the least mean that because of an awareness of the inevitability of such events that there are not attempts to engage in healing or cures or that death is not feared. Indeed, throughout the Eastern world medicine is seen as one of the most important of all branches of learning, together with astrology, grammar and logic.

However, it should be stressed that the therapeutic approach and the way that the individual should prepare for death are heavily based upon a religious view of life. Indeed, medicine is not seen as a discipline with its own cultural autonomy but as part of the vast conceptual system produced by the teaching propagated by Buddha.

The central reference point is the concept of the world understood as being both mental and physical at the same time. Life, it is believed, is not something attached to individuals alone but is a global phenomenon which links all living forms in a unique project which in its ultimate essence is mental – the nature of the mind is the nature of all things. It is above all else the Tibetan point of view in relation to pain and its possible remedies that will be examined here – in full awareness that the subject of this paper will not be deviated from by choosing such an emphasis – because the Tibetan medical tradition is an integral part of Tibetan Buddhism. The knowledge derived from Indian and Chinese medicine also forms a part of that tradition.

Furthermore, I think it is important to remember that after the Arab conquest of Persia the distant influence of Greek medicine could be felt in Tibet during the period of the monarchy, that is to say from the seventh to the ninth centuries after Christ. Historical sources refer to a *Ga le nos* at the court of the Tibetan king as well as a Chi-

nese physician and an Indian medical practitioner. The name is a clear reference to Galenus of Pergamos who lived in the second century after Christ. It is not impossible to argue that a Persian doctor belonging to the Greek school – and thus named Galenus accordingly – came to live in Lhasa during that period.

Tibetan medicine approaches the patient with reference to the whole of his person whose physical, emotional and spiritual aspects are thought to be inseparably unified in the individual being. Furthermore, man is seen as an organic part of the biological and cosmic universe and subject to all the immutable and unchanging laws of nature – in this way the microcosm of an individual is an exact copy of the macrocosm of the universe. It is believed that a human being is the product of the temporal conjunction of five orders of phenomena which are in a state of constant mutation, and more specifically the body, sensations, perceptions, impulses and consciousness. The consciousness is the beginning which arranges all sensorial information and is therefore the seat of discorsive thought. Sustained by a subconscious which is conditioned by past experiences, this consciousness trasmigrates from one existence to another when, at the moment of death, the elements which make up the individual's body disintegrate. In all its aspects – from the most important to the smallest – the body, in substantial terms, is thought to be nothing else than a complex and diversified aggregate of the five elements which go to make up the whole universe: earth, water, fire, wind and space.

In order to express this concept in more precise terms, it should be stressed that for Tibetans the body functions thanks to the present of seven component elements – the nutritive essence, blood, flesh, adipose tissue, bone, marrow and regenerative fluid; of three secretional functions: faeces, sweat and urine; and three so-called humours: wind, bile and phlegm. The humours are seen as being both physical – as the breath of breathing, bile accumulated in the gall bladder, and mucous secretions in the stomach – and as something produced by the cosmic elements and as a result reflective of their properties. Thus wind is an expression of the element of air which has characteristics such as lightness, mobility and so forth; bile is an expression of the element of fire which has characteristics such as warmth, fluidity etc; and phlegm is an expression of the elements of fire and water and has such characteristics as heaviness, slowness, softness and so forth. Through their cohesive relationship or otherwise the humours regulate and condition the health of the organism and influence the seven constituents and the three secretional functions.

Tibetan medicine first of all treats the mental attitudes and approach of the patient and his relationship to the three humours of the body. This is because mental and physical health are said to depend upon the state of harmony and balance of the five elements which in turn can be disturbed by external or internal causes such as thoughts or bad actions. The Tibetans believe that when hatred, greed or ignorance come to disturb the three humours (namely wind, bile and phlegm) illness breaks out. For this reason, Tibetan medicine has been defined – and with very good cause – as one of the oldest wholistic and psychosomatic forms of medicine that we know about and which is still being practised during the contemporary age.

Diagnosis is based first of all upon the information which is gathered from asking the patient about his symptoms and from taking his pulse and examining his tongue and his urine. When it comes to treatment there is no one treatment which is exclusively organic in character. The therapy involves providing the patient with the prescription of a suitable diet, advice regarding behaviour and activity, the application of medicines and external medical treatment. It is interesting to observe that prior to any form of therapy or cure a suitable religious rite has to be engaged in. There is a vast literature on this subject in which all those Tibetan texts which are called "long life rituals" and "prayers and rites for the maintenance of good health" should be placed. Quite beyond what may seem to us to be religious magic, it should be grasped that prevention is the first aim of Tibetan medicine.

The basic substances of Tibetan medicine (there are 2,294 in number) are herbs, precious stones, minerals, and plant and animal juices and secretions. The medicines which are prepared with these substances are then prescribed as decoctions, powders, pills, syrups, mineral oils and ashes. The Tibetan medical texts contain explanations by which to combat 1,616 illneses and indicate and describe over a thousand forms of medical treatment. The provision of medicines is seen as a light method, whereas such techniques as bleeding, cutting, moxibustion and the use of golden needles are considered to be a strong forms of medical treatment.

There is also the so-called violent method which involves small surgical operations where

foreign bodies are removed; the cauterisation of abscesses; and the destruction of seriously damaged tissues.

According to people who have lived in the medical centre of Dharamsala in India, the residence of the Dalai Lama and many Tibetan refugees, the Tibetans believe that ability to bear pain and have these surgical operations without recourse to anaesthetics is a virtue. However, it would be reductive not to refer to this aspect of Tibetan Buddhism which finds its highest point in meditation – something which provokes so much fascination in the West.

I am referring here in particular to Tantrism by which I mean that whole set of instructions and methods concerning spiritual concentration which bring out to the full the possibilities of the human mind and which are also of great importance for that part of the medical approach which is most mental and spiritual. Through the Tantric meditative technique there is generated, for example, what the Tibetans call *gTum mo*, that is to say the practice of psychic warmth which is also able to raise body temperatures thereby making survival possible for those who know how to engage in this practice even in extreme conditions. There is also the practice which the Tibetans call *bCud len* which involves being able to live without food for a certain period by eating only pills made of powdered minerals or flower petals. Thanks to Tantric meditation it is also possible to produce the so-called "seeds of blessing" which are perhaps similar to those substances which for us are the endorphines and which provide spontaneous protection against both mental and physical forms of pain and suffering.

It is also possible through meditation techniques to be able to see what the Tibetans calls the "Clear Light". By this phrase is meant the most sophisticated level of the mind which becomes manifest only when all the large organs and members of the body have halted their active functions. This is thought to be a condition which is normally reached at the moment of death but which can also be induced intentionally with the technique of meditation. The greatest distance which separates the Tibetan Buddhist world and the West is that constituted by approaches to death. This is a result not only of the belief in the samsaric cycle but primarily because of the attitude of Tibetans towards death.

Over time in Tibet what we might call a real and authentic *ars moriendi* has developed. In the West the *Bar do thos grol* or the Tibetan "Book of the Dead" is well known. This is a text which the Tibetan tradition attributes to the eighth century of our era. The tradition of the title means: "self-liberation through hearing during the intermediate period". The intermediate period is the time which Tibetans experience between physical death and subsequent rebirth and which can be compared to those pre-death experiences which in the West are currently the subjects of scientific research. The person who dies conserves a conscious principle upon which the lama who helps him can act by reciting a text. Through this reading – if the dying person has been suitably prepared during life – the individual can be guided towards a freeing knowledge which enables him to achieve a suitable rebirth, if not even complete liberation from the existential cycle. To conclude this section of my paper I would like to refer to what the fourteenth Dalai Lama of Tibet has written on the subject of death: "meditation on death and impermanence should be inspired by great pleasure. It is very important to be aware and conscious of death: if a person has been preparing for it for a long time he will not be upset by its arrival, but if a person avoids the question of death and tries to forget about it then he will be caught unprepared and he will be frightened when the moment of death arrives".

Those listening to my paper will not have failed to notice that from certain points of view the Christian and the Buddhist visions of life, death and pain – although profoundly different – have a number of points of contact. It is not inappropriate to refer to the serious danger which is now before us that the religious, cultural and medical traditions of the world will become extinct, and that the Tibetan people themselves in this tragic hour of their history will meet the same destiny. From another point of view I would venture to observe how the Christian message in the field of assistance to the sick has been able to generate sublime examples of humanity and that this too is endangered by marginalisation in the contemporary world. I would like to conclude this paper by referring to what Cristrina Campo writes in the preface to the work *Nato in Tibet* by Chogyan Trungpa where she attributes to the disappearance of the vertical dimension of thought the responsibility for so many evils of our contemporary culture.

Professor ELENA DE ROSSI FILIBECK,
Professor of Tibetan Studies, "La Sapienza" University of Rome.

Paper presented at the conference organised by the "S.Pietro" Hospital in Rome on the subject of "Chronic, Malign and Benign Pain", Rome, 16 March 1998.

Bibliography

G.L.MASARAKI, *Tibet, Magia e Medicina* (Istituto Riter, Milan, 1989).

SOGYAL RINPOCHE, *Il Libro Tibetano del Vivere e del Morire* (Ubaldini ed. Rome, 1994).

S.NATOLI, *L'Esperienza del Dolore. Le Forme del Patire nella Cultural Occidentale* (Feltrinelli ed., Rome, 1987).

VAIDYA BHAGAWAN DASH, *Encyclopaedia of Tibetan Medicine* (Delhi, 1994, 3 vols.).

VAIDYA BHAGAWAN DASH, *Materia Medica of Tibetan Medicine* (Delhi, 1994).

GYURME DORJE, YURI PARFIONOVIC and FERDINAND MEYER, *Antica Medicina Tibetana* (Zanfi ed. Modena, 1994), Italian version edited by Antonella Comba.

NAMKI NORBU, *Il Libro Tibetano dei Morti. Magia e Religioni* (New Compton, ed., Rome, 1983).

TENZIN GYATSO ZIV DALAI LAMA, *La Perfetta Felicità* (Studio Tesi ed., 1995), Italian translation by Federica Meret from *Path to Bliss: a Practical Guide to Stages of Meditation* (Ithaca, 1991).

W.Y.EVANS-WENTS, *Lo Yoga Tibetano e le Dottrinbe Segrete* (Ubaldini ed. Rome, 1973).

YESHI DONDEN-JEMPA KELSANG, *Il Tanta della Medicina Tibetana* (Ubaldini ed., Rome, 1980).

CHOGYM TRUNGPA, *Nato in Tibet* (collana documenti di cultura moderna, Borla ed., Turin, 1970).

E. DE ROSSI FILIBECK, *Catalogue of the Tucci Tibetan Fund in the Library of ISMEO* (Rome, 1994, vol. 1).

M.PIANTELLI, 'Il Buddhismo Indiano' in G.Filoramo (ed.), *Storia delle Religioni. Religioni dell'India e dell'Estremo Oriente* (Laterza ed., 1996).

Evangelisation in the World of Mental Health: Foundations and Guidelines for Action

For the followers of Christ, his work is the model of inspiration and the decisive criterion for determining the character of evangelising action and capturing the spirit which should animate it. Only in the light of his work can we establish the bases for evangelisation in the world of mental health and suggest certain guidelines for action.

I. The Work of Christ in the World of Mental Infirmity

Jesus proclaimed and offered the salvation of God, not in any kind of way but by generating health and by doing good in the world of illness and suffering. Jesus made himself present where life seemed to be most deteriorated, tormented, and worn out, and only beginning with a liberating and beneficial action for these men and for these women did he preach that God was the Saviour, the Friend of life and the ultimate happiness of every human being.

To move to a practical level, I will point out four aspects of the work of Jesus in the world of mental infirmity: 1) 'making room'. Jesus welcomed these sick people and made room for them in his life; 2) 'saving the lost'. Jesus strove to save those who seemed to be lost; 3) 'defending the weak'. Jesus defended the abject, the victims of evil; 4) 'communicating with the excluded'. Jesus included the sick people excluded by society in his life with others.

1. The healing of the mentally ill man from Gerasanes

Before studying the work of Jesus, we will dwell upon a well-known episode – 'the healing of the possessed man of Gerasanes' which appears in the synoptic tradition (see Mk 5:1-20; Mt 8:28-34; Lk 8:26-39). We have before us a surprising scene in which is demonstrated in clear brush-strokes the evangelising action of Jesus in the mysterious and tormented world of mental illness (of those 'possessed by devils' according to the mentality of the epoch).

The situation of the sick person was tragic. He was the victim of an 'unclean spirit', that is to say he was distant from the Holy God, without God; 'he ran amongst the rocks' in a condition of total and wild loneliness. 'This man made his dwelling among the tombs', and he was excluded from the world of the living. 'He had been bound with fetters and chains often before' by a society which only thought about defending itself against him. He was a sick man who could not be redeemed, 'nobody had the strength to control him'. He lived 'crying aloud' phrases that nobody could understand and he was unable to communicate with anybody. 'He cut himself with stones' and was the victim of his own violence. Jesus met him and the sick man cried out to him in a loud voice: 'why dost thou meddle with me, Jesus, Son of the Most High God?'. What did Jesus, the Son of God, have to do with this dark and painful world of mental illness? The evangelists describe the work of Jesus in great detail. Jesus asked the possessed man his name; he wanted to help him to recover his own identity: 'What is thy name?' The sick man answered: 'My name is Legion; there are many of us'. He was a divided man, a man internally fragmented by his illness. Inside him there was a confused world of division and of pain. Jesus then said to him: 'Leave this man, unclean spirit'. Make way for the Spirit of God, make room for reconciliation, for peace, for inner liberation, for the growth of this person.

Luke describes the transformation of this sick person very well. When people arrived they found the man 'sitting... at Jesus' feet'. Those who had witnessed the event told them 'how the possessed man had been delivered'. Jesus placed in that life a new equilibrium, he released the man from an infrahuman state, and provided him with a new quality of life. But in addition he communicated his words to him, he gave him faith. The possessed man was not only healed he was a 'saved' man. He was a disciple of Jesus.

Lastly, Jesus integrated him once again into society. He broke him away from the loneliness of the mountains and the tombs where he had previously lived out his existence. He released him from his isolation and his segregation and brought him back to life, to home, and to living with others. 'Go home to thy friends, he said, and tell them all that the Lord has done for thee, and what great mercy he shewed thee' (Mk 5:19). And he went to the Decapolis and proclaimed 'what Jesus had done for him' (Mk 5:20). That man was transformed into the Gospel, into the Good News of God. In him was manifested the 'mercy' of God for human beings.

2. Jesus draws near to the world of mental infirmity

This is the first thing that we should observe. Jesus drew near to sick people but at a more practical level he drew near to the mentally-ill. In the long list of sick people whom Jesus took care of, reference is constantly made to those kinds of sick people who in that epoch were thought to be possessed by Satan and bad spirits. Jesus healed the sick but also expelled demons. He went through Galilee 'preaching the gospel of the kingdom, and curing every kind of disease and infirmity among the people... they brought to him all those who were in affliction, distressed with pain and sickness of every sort, the possessed, the lunatics, the palsied; and he healed them' (Mt 4:23-24; Cf. Mk 1:34 and Lk 6:18-19).

In order to understand this action of Jesus correctly, we must remember how mental illness was viewed by the society of the time. In the Semitic mentality, every sick person was a person who had been abandoned by the Spirit of God – that vital breath

with which God sustains every person. For this reason, the sick person was always a person threatened in his or her own being, a person who was walking towards death, who was falling into an oblivion without God. For this reason, the sick Jew lived out his or her own illness as an experience of powerlessness and abandonment, and what was truly terrible, of abandonment by God. After a certain fashion, every illness was a punishment or a curse of God, and a sick person was a person 'wounded by Jehovah'.

The situation of the mentally-ill person was even more tragic. Such a person was so emptied of the Spirit of God, so abandoned, that his or her person was invaded by Satan and malign spirits. Satan was evil by definition, the personification of everything that destroyed the salvific plans of God, he who destroyed human beings and tormented them. The Jews spoke about Satan when they referred to a person subjected to an inexplicable and mysterious affliction which generated fear and was threatening. For this reason, the mentally-ill person was an individual abandoned by God and possessed by evil, someone against whom one had to defend oneself and from whom one had to flee.

In this socio-religious context, Jesus 'makes room' in his own life for these men and these women who have no place in society and, it would appear, not even in the heart of God. This is the fundamental fact. The sick person was the prototype of the 'abandoned person'. Jesus welcomed and made room for these sick people who lived in the world but without the world being for them a home, for those who had nowhere to go, for sick people who were rejected, who did not know to whom to turn, who clashed every day with the raised barriers of those who were healthy, who were safe. Jesus showed them that they were not alone and that they were not abandoned.

3. Jesus saves the lost life of the mentally-ill

Saving what is lost is another aspect of Jesus, indeed almost an obsession. Jesus spoke in his parables about 'lost sheep', about the 'prodigal son', and about the 'lost coin' (Lk 15). He felt that he was sent to the 'lost sheep of the house of Israel' (Mt 15:24) and proclaimed that 'the Son of man has come to search out and to save what is lost' (Lk 19:10). Jesus, the friend of life, drew near to the world of the sick in order to save what was lost, deteriorated health, and worn-out life. He was the hope of the lost.

It is for this reason that we encounter Christ amongst those who are mentally-ill, amongst the alienated, amongst those who have been corrupted, who have lost the meaning of their lives and their identity, amongst those who are possessed by evil, those condemned to insecurity and fear, amongst those who experience their own affliction as something which cannot be remedied. Of those who study 'the movement towards the low' which is characteristic of Christ, C.H. Dodd observes the 'unprecedented interest for the lost' and L. Boff emphasises that Christ directs his preference towards the 'non-men'. If Christ drew near to mentally-ill people it was simply because he was moved by his very deep love for these lost beings and by his passionate intent to release them from the disintegrating power of evil. The first Christian community had this memory 'about Jesus of Nazareth, how God anointed him with the Holy Spirit and with power, so that he went about doing good, and curing all those who were under the devil's tyranny, with God at his side' (Acts 10:38). Such was Jesus: full of the Spirit of God he went about freeing and healing those oppressed with evil and by inner division ('devil' = 'he who separates').

I would like to observe that in the gospels the possessed (the mentally infirm, epileptics etc.) are never described as sinners, as morally bad men, but as the defenceless victims of evil. For this reason, the struggle of Jesus was not against the sin of these men but against the evil which tormented them and destroyed them.

Jesus freed them from loneliness and isolation. He liberated them from inner confusion, from division, and from alienation. He freed them from the torment of illness, from fear of God. He infused 'peace' into their lives, 'shalom', that is to say blessing, grace, well-being, security, and trust in the future. This is what Jesus placed in every sick person: 'go in peace

and be rid of thy affliction' (Mk 5:34). Jesus, full of God, transmitted life, health and blessing to the mentally-ill: 'the Son of God was revealed to us, it was so that he might undo what the devil had done' (1 Jn 3:8).

4. Jesus defends the weak sick person

There is another fundamental aspect to Jesus: he always defended the weak, the defenceless, and those who could not assert themselves. Jesus spoke often about 'the little ones', of those who were not great in anything, of those who did not have the power or the strength to defend themselves. 'See to it that you do not treat one of these little ones with contempt' (Mt 18:10). 'So too it is not your heavenly Father's pleasure that one of these little ones should be lost' (Mt 18:14). 'Believe me, when you did it to one of the least of my brethren here, you did it to me' (Mt 25:40).

For this reason, we see Jesus defending the mentally-ill, who did not have any prestige or power, who were without an image and without an identity, who were poor not only at the level of possession but also poor in the poverty of being, poor in terms of a conscious and affective life, and without the power to present coherent views, being as they are isolated and divided by affliction.

Jesus defended these people against that society which excluded them and condemned them to live in solitary and far-off places; he defended them against laws and taboos which despised them as being impure. He was not afraid to touch them and to free them from impurity and from contempt. He was so committed to their defence that soon he, too, was identified with the possessed: 'He is possessed by Beelzebub; it is through the prince of devils that he casts the devils out' (Mk 3:22). He was seen as being mad and possessed: 'He is possessed by an unclean spirit' (Mk 3:30).

But Jesus also defended these men and these women from the power of evil. He saw these sick people as the victims of something that was 'strong' and had entered them and enslaved them. He felt that he was 'stronger' and could liberate them from affliction. 'No one can enter into a strong man's house and plunder his goods, without first making the strong man his prisoner' (Mk 3:27). Jesus committed all his authority and strength to free these sick people from their affliction: 'he has authority to lay his commands even on the unclean spirits, and they obey him!' (Mk 1:27).

5. Jesus integrates sick people into society

In Israel, the mentally-ill person was the prototype of the excluded person. Possessed by Satan, he or she was considered impure. Such a person did not belong to the holy community, to the people of God. He or she did not know the law and he did not carry it out. He or she could not enter the Temple. Such a person was excluded from society, condemned to live in solitary places distant from inhabited cities and was stigmatised both socially and in religious terms.

The gospels repeatedly observe the efforts made by Jesus to reintegrate sick people into society. Thus he proclaimed to the healed paralytic: 'Rise up, take up your bed and go home' (Mk 2:11). The same thing happened with the possessed man of Gerasanes. Jesus made him leave the loneliness of the mountains, made him break with loneliness and segregation, and led him back to life.

The sick person expressed his wish to stay with Jesus but Christ wanted him to go home. He had suffered enough being distant from his kin. He had to go home and proclaim that the Lord had had mercy on him. The return to a normal life was seen as a grace of God. 'Go home to thy friends, he said, and tell them all that the Lord has done for thee, and what great mercy he shewed thee' (Mk 5:19-20).

6. The proclaiming of the salvation of God

The work of Jesus in the world of the mentally-ill was not one medical action amongst many other such medical actions. Curative activity was not being engaged in. Jesus gave this work a deeper and evangelising meaning. 'if when I cast out devils, I do it through the Spirit (Lk: finger) of God, then it must be that the kingdom of God has already appeared among you' (Mt 12:28).

Through his healing and humanising action, Jesus was a sign that God had not abandoned these sick people. They were not lost and abandoned. God was near to them. In definitive terms, the God of good and not of evil, the God of the creation, of health, of life, not the God of destruction, of illness, and of death. The ultimate purpose of the healing action of Jesus was to show that even in this dark and painful world of mental infirmity God reigns as a friend of human beings.

II. Major Guidelines for Action

The work of Jesus enables us to discern and outline certain basic guidelines for evangelising action in the world of mental health.

1. Drawing near to the mentally-ill person

The first such form of action, without doubt, is to stimulate within the Church a greater sensitivity and a change of mentality which draws us close to the world of the mentally-ill person and his or her family.

1.1. Unknown and feared

Today, Christian communities are making a very significant effort in the world of the most in need and least helped sick people. However, with the exception of the generous dedication of certain religious Orders and Congregations and certain sen-

sitised groups, the mentally-ill and those people who are most absent from the evangelising concern of the Church and of Christian communities.

There can be no doubt that there has been a growth in sensitivity towards those who suffer from depression, from senile dementia, and towards alcoholics and drug-addicts who are afflicted in their personalities, but we cannot observe, at least to the same extent, a change of approach towards, and a greater nearness to, mentally-ill people. They are the people who are most in need, but they are also the most unknown and the most feared. Between this world of suffering, of darkness, of loneliness, and of destruction, and the life of Christian communities, there seems to be raised a kind of invisible wall which prevents people from drawing near to the mentally-ill and from understanding their pain and suffering, and this is something which obstructs evangelical communication, the gospel-based presence.

1.2. Overcoming negative connotations

At the root of this distancing of the mentally-ill a series of negative connotations are at work which must be addressed in a more positive and Christian way.

In the first place, and this is something which has been true ever since time begun, there is the image of what is dangerous which is associated with mental infirmity, and this is something which rapidly leads to the isolation and the shutting away of the sick person in order to defend society against the threat that he or she represents. A more rigorous knowledge and a spirit nearer to Jesus should lead Christian communities to adopt a more realistic and differentiated position and an approach which involves greater welcoming.

Secondly, the most important expressions of mental infirmity are behavioural disturbances. And it is specifically these changes in behaviour, which are deviant from what is considered 'normal', that create insecurity and impede us, or make it difficult for us, to draw near to the painful reality of mentally-ill people, given that we seek to defend our 'normality'. A healthy awareness of our weaknesses and a more realistic acceptance of our limits, together with a radical love for these human beings, would allow us to draw near to them in a more welcoming and understanding way.

At the same time, it is easy to see the mentally-ill man or woman as a person who is incapable of any real communication and personal growth. What can be true in some of the different varieties or stages of mental illness, extended in erroneous fashion to every sick person and to all the fields of human experience, becomes transformed into an obstacle to a more human and constructive drawing near. The approach of Jesus, which amounted to 'seeking out and saving those who are lost', should give life to a very different approach.

Lastly, to all this is to be added the general idea that mental illness cannot be cured, that one can do little or nothing about it. Quite apart from what the experts and specialists may say and can do in individual cases, it should be remembered that when one cannot treat one can and one must accompany, alleviate, defend, and love.

1.3. Giving an impulse to drawing near

Animating the Church in a process of drawing near to the world of the mentally-ill involves various aspects. I will now list some of them. First of all, we should look anew at the role that mentally-ill people have in the memory and the concerns of Christian communities; promote a campaign of sensitisation and of change in approach in relation to the mentally-ill; effect a more real drawing near to the world of mental health (psychiatric hospitals, psychiatric units in general hospitals, mental health centres, etc.); achieve a greater knowledge of the sick people who belong to our own Christian community; and secure closer contacts with the families who suffer with a loved sick person amongst them, etc. This is a matter, in definitive terms, of 'making room' for the mentally-ill person in the heart of the Church and within the Christian community.

1.4. The need for training

A healthy drawing near to the world of mental infirmity requires a minimum of rigour and competence; making the relationship more healthy and beneficial for the sick person; knowing how to keep the right distance; developing a style of positive communication; and co-operating in a therapy of support for the mentally-ill person.

All this requires training. Good will is not enough. With the best of intentions one can interfere in, or obstruct, therapeutic work. Those working in pastoral care for mentally-ill people must acquire a specific minimum training in order to know the possible reactions and attitudes of the sick person, and the most suitable way by which to secure a positive relationship with him or her. Hence the need for close and effective co-operation between psychiatrists and experts in mental health and groups and people who approach the mentally-ill person with a different and non-specialised perspective made up of human and Christian friendship. This co-operation or 'alliance' at the service of the sick person, in

which each person maintains his or her own identity and responsibility, would constitute, in my opinion, one of the most positive signs of real interest in achieving overall care for the mentally-ill person.

As regards Christians, whether medical doctors or medical staff, who work in the field of psychiatry, in addition to everything that they can teach us, and they can teach us a great deal, it should be said that they also have the right to find us at their side in relation to other believers in order to search together for the evangelising meaning of their work and to illuminate the problems that mental health raises for a Christian vision of existence.

2. Introducing the blessing of God

It is not enough to be present in the world of mental infirmity. We should ask ourselves what this presence should be and what should be adopted to make it evangelising, like the presence of Jesus.

2.1. Towards an evangelising approach

Drawing near to the mentally-ill person can have different emphases. If the mentally person generates distrust and fear because of the fact that he or she is dangerous, an approach involving caution and care should be developed. If one wants to combat his or her deviant behaviour, measures of a corrective character should be developed which are directed towards reducing and attenuating the illness. If one is trying to retrieve the healthy aspects of the sick person and to provide an impulse to his or her growth and development, therapeutic treatment should be promoted. Without denying the relevance of these actions in every case, and respecting the skill and expertise of experts in psychiatric help, the evangelising approach bears in mind above all else that there is before us a poor and suffering human being who needs love and blessing. Without denying the paths of psychiatric help or psychological wisdom, indeed these are to be included, there exists a pathway by which to reach the broken life of the mentally-ill person: active compassion, patient love, and communication which transmits blessing.

2.2. Imposing the blessing of God

To bless (from the Latin 'benedicere') means literally 'to speak well', to say good things to someone and above all else to speak about our love, to express to him or her our good will. According to the French psychoanalyst Françoise Dolto, 'to bless' is to do good. It is like saying: 'I want your good. I will think of you, I will not want anything but good for you'. This is what is really important: the certainty that a human being will receive a blessing (Concilium, 198, March 1985, 254). This is a matter, therefore, of being together with mentally-ill person in an approach marked by blessing, which means leaving behind the stigma of being badly born, of being badly made, of being cursed; of addressing with benevolence those who seem to be marked only by a curse; and of treating with love those who seem to be marked by affliction.

It involves 'blessing in the name of God'. Communicating with gestures, words and approaches the love of God who does not abandon these broken and stigmatised lives. Telling the mentally-ill person that he or she is blessed, that God is aware of him or her, sees him or her, and loves him or her infinitely. Giving back to him or her the certainty that he or she is a being loved by God with fathomless and freely-given love.

For this reason, to bless is to ensure that the sick person is enveloped in love, even though he or she is not able to understand this fact in a conscious way. It is placing a silent love which is recognised only by God in this life. It is placing a freely-given love that illuminates this life, which at times is so dark and impenetrable. It is placing peace and grace where there is only an excess of affliction.

Naturally enough, blessing is not an isolated gesture. It needs to be maintained. Indeed, the sick person needs constant proof that he or she is accepted and loved. He or she needs benevolent words and gestures, communication, company, care, welcome and tranquillity. The sick person needs to know in one way or another that whatever he or she does and says there will always be grace and mercy for him or her, that there will always be somebody who will take care of him or her and try to achieve his or her good.

2.3. The style of blessing

Blessing requires its own style of implementation. First of all, as a support for all the care and attention towards the sick person, freely-given love is required. This love cannot be based upon mutual giving, and cannot require such a thing. Those who take care of these sick people and live with them by blessing do not act out of personal interests, or for reasons of fear or because of apprehension. Those who bless do not have fear. They only have love for the search for the good of the person who is blessed.

This love is made up of total respect for the sick person, not because of his or her human maturity or his or her natural dignity, but simply because he or she is a person, an image of the living God, the loved son or daughter of the Father. Those who bless are concerned with the deep mystery of which every human being is a bearer, and this is even more the case with this kind of sick person, who is at times without inner freedom and has been transformed into something that is foreign and dark for himself or herself.

Those who bless act by listening with compassion to the suffering of the sick person, to this life which has been transformed into torment. Those who love this sick person seek to grasp the overall message of this sick person, what he or she wants to tell us (although what he or she says is not coherent), what he or she wants, and what he or she needs.

At the same time, drawing near to the mentally-ill, as is the case in drawing near to every being who is deeply in need, makes us humble. A certain result or spectacular results are not possible. We cannot extirpate the affliction at its roots. We cannot save. Those who bless in the name of God work with humility and patience beginning with faith and hope in God, the only definitive saviour of man.

3. Defending the mentally-ill person

Evangelising work in the world of the mentally-ill can find concrete expression in the task of defending the mentally-ill person by giving him or her a more human and dignified place within the Church and society.

3.1. The defence of rights

A Church faithful to the spirit of Jesus, and some Christian communities rooted in his work, must know how to defend the dignity and the primary importance of the sick person against everything connected with neglect, marginalisation, abuse, or insensitivity.

This means in practical terms defending the right of the sick person to suitable health care; the right to the best possible quality of life; the right to individualised forms of treatment; the right to overall care and concern for his or her various family, social, and religious needs; and the right to see his or her ethical and religious values respected.

This is not a matter of defending the sick person in theoretical terms, from outside, but rather of co-operating in everything that could involve an improvement in prevention, in treatment, in rehabilitation, in overall care, and in the social integration of these sick people. The role of voluntary workers has been decisive in many European countries in obtaining improvements that would not have been possible without this kind of co-operation.

3.2. Social integration

Gospel-based action which is rooted in Jesus involves the promotion of communion with these sick people, who are, indeed, discriminated against and marginalised in many ways. It is not enough to defend the 'de-institutionalisation of psychiatry' if we want to reinsert and integrate these sick people into society. A complete work of sensitisation and a complete change in mentality are required in order to alter the existing social approach to mentally-ill people. We need to welcome and to be near to these sick people without marginalising them; to support their families and offer them the necessary resources and help as the first means by which to obtain such integration; and to take care of mentally-ill people who are homeless and drift from one place to another.

Christian communities and workers in pastoral care in health here have a major task to carry out at the level of sensitisation, help for families, co-operation with the associations made up of the family relatives of mentally-ill people, etc. There can be no doubt that one of the best ways by which to contribute to the social integration of mentally-ill people is to make room for them in Christian communities, to restore to them their 'right as members of the community', and to open to them the doors of the parishes, inviting them to take part in the life of the community and facilitating their presence at celebrations, meetings or activities, from which, indeed, there is no reason for them to be excluded.

3.3. Religious care

One of the areas where the Church can best demonstrate her evangelical and evangelising countenance towards these sick people is through religious welcome. There can be no doubt that the situations vary. Experts speak about sick people whose religious life is practically in

tact, about sick people whose religiosity is an obsession, and about sick people whose religious behaviour is deviant or extinct. Reliance must be placed on those who strive to help mentally-ill people and restore their health. They should be co-operated with in order to act in the safest and most beneficial way for the sick person. But it should never be forgotten that from the action of Jesus there stands out a general criterion: there should be an overcoming of everything that involves marginalisation, isolation, distancing, and prohibiting, and a promotion, instead, of everything that involves living with, drawing near to, welcoming, and integrating.

From the perspective of the believer, what matters in all this is to remove obstacles and humbly help so that in these people, too, there takes place a meeting of the mystery of God with the mystery of man. This is the thing which is of primary and decisive importance. As regards all the approaches that one can have in relation to the fact that the mentally-ill person is a subject of religious life, and in concrete terms a subject capable of receiving the sacraments, I will merely read the words of the priest and psychiatrist, Mariano Galve, with whom I identify totally: 'I am amazed when I hear that the sacraments are denied because 'the subject is absent'. And I will say why this is the case... In psychiatry the subject is here, in front of us, obsessively in front of us, with a reality that one cannot mask or describe, in a cruel and shameless way. It is certainly the case that in most instances, when he or is she is not a reluctant and unreachable, unintelligible and fleeting, subject, he or she is a bad, empty and distorted subject. He or she is an ambiguous, rambling and destroyed subject. But there is a subject, and an evangelical subject... 'I did not come to heal the healthy but the sick... I came to find who was lost'' (in 'Objectivos y actividades del quehacer pastoral en psichiatria', November 1986).

Here three fields deserve a more detailed analysis. 1) The sacrament of reconciliation as a place of welcoming and peace-making, a place for blessing and grace, a propitious field for the deep restoration of the person (self-esteem, friendship

with God); 2) the celebration of the Eucharist with its various aspects: the welcoming and participation of sick people as members of the assembly; action of thanks to God who is a friend; listening to the Good News of Jesus; drawing near to communicate with Christ; receiving the blessing of God; 3) prayer with the sick and for the sick; helping to find the right prayer, accompanying in prayer, invoking and thanking God together. Listening together to his Word.

4. Supporting the family

Reference is made to reinsertion and the social rehabilitation of mentally-ill people, but this is difficult if families are not supported to a greater extent, and the family is the first and principle sphere of reference, in general, for reintegration. Families need greater resources and greater support in order for them to be an effective support in the rehabilitation of the sick person.

4.1. The situation of families

There can be no doubt that the situations of families vary a great deal, just as in the same way there are major variations in the approaches towards the sick family relative adopted by the other family members. But it is nonetheless possible to point out certain rather common aspects.

Many families feel that they are alone and that they have little support in facing up to the problems that arise because of the illness of one of their members (a parent, a son, etc.).

At the same time, families often feel that they are marked out in relation to other members of society. There is a fear of what 'people will say' and an attempt is made to hide the illness because it is something which is dishonourable for all the members of the family.

A feeling of guilt can also arise. The illness can be an hereditary phenomenon; there can be recriminations about not having perceived it earlier or about not having taken care of it in a serious way etc.

In some cases a fear of the sick person can arise on the grounds that he or she is dangerous or because of the problems that he or she creates in the family environment and in the more general environment.

Certain difficulties are born of an economic character, problems at work and to do with administration, consultations with medical doctors etc.

Dr. V. Beramendi very effectively describes the powerlessness or fear which often arise because of these family dynamics: 1) fear about admitting the person to hospital (the sick person will ruin the family, he or she has to be hidden away, what will happen?); 2) fear during the hospitalisation (fear that he or she will not be treated, fear about the discharge from hospital, about the reactions of the sick person, visits that are not wanted, etc.; 3) fear after the discharge (the risks of living with the person, fear about the unpredictable consequences of the behaviour of the sick person, fear that he or she has not been subjected to effective care and treatment, etc.).

In this situation there are families which look after their sick member well, with love, patience, competence, and by co-operating in a positive way with the medical doctors. But there are also families where the sick person is an insupportable burden; who are not able to deal with him or her, and whose members are negatively affected and in turn foster a deterioration in the condition of the sick person.

4.2. Support for families

Christian communities must be very near to these families. This is in turn one of the most important fields of action for the parish communities.

First of all, the families must be known about, drawn near to, and their problems listened to. The measures and the channels to be near to them and to accompany them to solve their various problems or at least to alleviate their situations must be sought out.

The forms and the kinds of help are many in number. There are no recipes. In each case the needs which must be met must be identified. It may be necessary to liberate these families from isolation and provide them with security; they should be informed about their rights and defended in practical terms; they must be helped to look after the sick person and in the carrying out of various tasks; and they should be put in contact with the associations of family relatives of mentally-ill people.

I would also like to draw your attention to homeless mentally-ill people, whose number is constantly increasing and who need therapeutic support and to be followed from close at hand. The special help of Caritas is not enough – more specialised action is required.

I would like to conclude with the testimony of the Marxist Lucio Lombardo Radice who describes one of the most characteristic aspects of Christianity in the following way: 'From a Christian point of view it is important to dedicate oneself to a human creature, look after him or her and love him or her, however much our dedication may not be productive. For the Christian it is important to give all his or her time with joy and happiness to the incurably ill person and to give it 'freely'; for the Christian it is important to accompany with love and patience the elderly person, who is already 'useless' and on his or her way to death; it is important to take care of the 'last' human beings, the most unhappy and imperfect, including those in whom it is almost impossible to discern human traits' *(I Marxisti e la Causa di Gesù*, 26-27).

Rev. JOSÉ ANTONIO PAGOLA
Diocese of St. Sebastian
Spain

The Anthropology and Ethics of Dying

I. Human Death and Dying

a. The human being faced with death

It is clear that man is a mortal being. This is a natural fact that we can do nothing about, although some people, for example Walt Disney, prefer to be frozen at -190E in the hope that after a few decades or a century medical science will be able to bring them back to life.

Heidegger said that man is a being-for-death and that not only does he die but he knows that he will die. Some adages which figure on certain ancient sundials such as 'tempus fugit' ('time flies') or 'carpe diem' ('seize the day') or 'memento mori' ('remember that you will die') remind us that sooner or later we will have to die, that just as we have come into this world so also we will have to leave it. Quevedo was right when he said that 'man is a being who lives between the cradle and the funeral shroud'.

b. Death and illness in contemporary culture

Speaking about death and illness is not something that is liked by anyone, as though they were subjects which were taboo and not to be raised. However, today we will speak specifically about illness and about death.

The world of illness is a difficult world but a compelling one. It is difficult because it is a world in which we move on the threshold of dualisms (hope/hopelessness, meaning/meaninglessness), but compelling because we enter into the very depths of the human being. In the world of death something rather the same takes place. Death is always something which takes us by surprise. It is premature, we do not know when it will arrive, and this is the specific reason for the anxiety it provokes. Death, for this reason, imposes itself on us, does with us as it will. And it is also a reality

which provokes fear in us: of loneliness, of pain, of a lack of satisfaction with a life which has been badly led and which cannot be lived again in a different way, a sense of guilt about having behaved badly towards somebody, and so forth.

Death is something which is uncomfortable, we are afraid to think about it, we think that it is something for other people and not for us. However, it is an inevitable reality, something which is natural to the existence of all living beings. There is in addition something curious and ambivalent in the approach of many human beings to death: on the one hand there is a wish to know, and on the other hand the fear of knowing, that is to say, there is the fear of knowing but there is also the fear of the unknown.

c. The terminally-ill person

Today it is estimated that the reason why 87% of the people who die in the world, principally in the most industrialised countries, is to be attributed to chronic or terminal illnesses. However, and despite that fact that at a medical level there is not a unanimity of criteria by which to define a patient as being 'terminal', we can say that a terminal situation is one in which a person reaches the end principally because he or she has an irreversible clinical state, that is to say that there is no therapeutic action which can avoid the progressive organic deterioration that will lead to death. Of the criteria which can be employed to diagnose the syndrome of a terminal illness, the following can be listed:

a. An incurable illness with a progressive development.

b. The prediction of survival of under a month (or six months at the most).

c. The proved ineffectiveness of treatment.

d. The loss of hope of recovery.

II. Living Dying

Plato said to his disciples: 'practice your death', 'practice dying'. Every day we experience small deaths, small signals (for example the death of a person dear to us, the loss of our usual work, emotional fracture or separation, etc.) to the point that one can speak about daily dying, on the one hand, and final dying, on the other.

We can say a great deal about final dying, but almost nothing about death, except what some people derive from parapsychology and others from faith. Unamuno said that he was not worried about dying but that he

felt anxiety about 'not existing', about ceasing to exist forever, and hence his yearning for immortality, his strong desire not to disappear forever.

With all this we must accept human finiteness and approach death as something which is inevitable. However, if one has to choose between the absurdity of not believing in anything and believing in something, I think that the second is preferable because nothing springs from the absurd whereas something valuable springs from belief - mystery.

a. Spirituality and transcendence

In all ages and cultures human beings have needed to believe in something that goes beyond daily life. Hence cults, funeral rites, etc. Every man has asked himself, asks himself, and will ask himself about the meaning of life and also about the meaning of death. In addition, as they grow older people adhere more closely to their own 'beliefs' and ask themselves about whether another life exists. During adulthood, or to express it more effectively during the maturity of old age, a rebirth of spirituality takes place.

This spirituality is nothing else but a search for the meaning of one's own existence, a way of connecting our 'higher self' to our 'inner self', or to what some people call God. Spirituality can be an impulse towards this transcendence but in many cases it is nothing else than mere help and mere consolation at difficult moments, above all else when death is experienced from near to hand (for example the death of someone because of a road accident, the terminal illness of a family relative or when one feels because one is of an advanced age that little time is left before one leaves this world).

We should also say that death is a good teacher regarding life. When you look at death face to face, life becomes transformed into a unique experience. In this sense we can say that death can give meaning to life. Death turns us to life, it reminds us that our time is limited, destined to end, and that we should thus take advantage of it. Hence the importance of enjoying our lives.

We should say here that it is more important to live the time that we have than to want to live as long as possible (quality is more important than quantity). A person can die at the age of thirty and have lived a great deal or die at the age of ninety and never experienced the important things of life. For this reason we should aspire to what Neruda said at his death: 'I confess that I have lived'.

b. Facing up to suffering

Suffering is another inevitable human reality. I will now attempt to list some ways by which we can live out suffering in a healthy way:

Suffering should be eliminated as much as possible. The first thing that we should do with suffering is to remove it where this is possible. This is even more the case if we are dealing with senseless suffering.

Bear inevitable suffering. In life there is a kind of suffering which in itself is inevitable: illness, old age, misfortune, the loss of dear ones, etc. These moments bring out the dark and painful side of life. This suffering can be alleviated or attenuated but it cannot be removed because it is a part of existence itself.

Face up to suffering with realism. In the face of suffering rather than making fine speeches or producing theories it is necessary to act against it. Rather than a passive approach or resignation, one should adopt a realistic attitude - it should be fought through optimism and hope (for example, the sick person who gives up and becomes depressed lives out his or her own illness in a worse way than the person who adopts the opposite approach).

Do not close oneself up in pain. If the sick person closes himself or herself in his or her own pain he or she becomes even more depressed. In the face of the risk of becoming darkened by his or her own suffering, the sick person must struggle to break the circle which imprisons him or her.

A meaning to pain should be looked for. The sick person should be helped to find a meaning to his or her suffering and this helps him or her to face up to and experience his or her illness in a healthier way. But the problem is not as Vikotor Frankl said to suffer, but to suffer without meaning. Perhaps it will not be easy to search for this meaning, and even less easy to find it, but an attempt is worthwhile.

c. Care for the dying

The ultimate demonstration of respect and affection in relation to the dying person is 'to be with him', to share his moments, to allow him to show himself as he is and to die in his own way (and not in our way). But it should be realised that the dying person has two fundamental needs: first, the need to feel the nearness of someone at the moment of death (although there are those who say that those who belong to Latin culture prefer to die alone and curled up), and second, the need to be able to draw up a final summary of his death. What elements constitute this care?

Elements:

Communication with the dying person: verbal: providing him or her with serenity and showing affection; non-verbal: expressions of the body and looks. As the Spanish saying has it: 'a gesture is worth more than a thousand words'.

Silence: staying at his or her side in silence can be a valuable experience.

Touch: physical touch is important for newly-born children, for mental and emotional development, and also for those who are at the ends of

their lives. Experience teaches us that almost everybody reaches out for other people's hands and this is because a caress is the most direct way of sharing love.

Hope: they should always have the hope that they will get better, live a little longer, or encounter a calm death.

d. The experience of mourning

Mourning is the natural reaction of a human being in response to the death of a loved one. This reaction can be a long journey, made up of two days, or of two years, or even of the rest of a person's life. It is useful to point out what could be the principal stages through which a person undergoing mourning usually passes:

Stages of Mourning:

Shock: (*distress*): a feeling of incredulity: 'it can't be true', 'I don't believe it', 'it can't be happening to me'.

Stage of anger: aggression, anxiety, confusion, self-rebuke, etc. (loneliness and isolation are engendered).

Stage of hopelessness: awareness is gained of the fact that the deceased person will not come back (deep sadness and uncontrolled weeping).

Stage of reorganisation: putting the pieces back together and the adoption of new life models without the deceased person (social life is taken up again).

Mourning for somebody is also an act of love. Sharing and helping a person during his or her mourning is fundamental to ensure that he or she accepts and takes in the fact that the person will no longer be present physically with him or her, even though spiritually that person will be present (of course not like Patrick Swayze in the film 'Ghost') and inside his or her heart.

III. Towards a Dignified Death

a. Ethical considerations

A popular idea exists about what is a good death and what is a bad death. A good death is said to be one without pain, to die what is commonly believed to be a natural death, or old age. A bad death is said to be to die suffering or from a death which was not sought for.

There are many authorities who have studied the subject and they have provided a series of more or less personal criteria on the question. But despite this variety of approaches it is possible to summarise what for many people are the fundamental rights required for a dignified death.

The right to know that one is about to die (the right to know the truth).

The right to express one's own faith (respect for the person's values and creed).

The right to be conscious (to die in a state of consciousness with one's eyes open), even though there are those who prefer to know nothing and to die in tranquillity.

The right not to suffer without good reason or needlessly.

The right to die 'naturally', without an extension of one's life or it being shortened.

The right to die in human contact with the people near to one (human warmth).

b. Preparing to die: believing, hoping, loving

It is difficult to day 'adieu' but we must learn to separate ourselves from our loved ones. For the Swiss doctor, E. Kubler-Ross, who is resident in the European Union, to die means to abandon one's physical body, in the way that a butterfly leaves its silk chrysalid. One is dealing here with passing to a new state of consciousness in which the spirit continues to exist. The same author also states that when they are on the threshold of death people see a bright light and that within it there are their loved ones who have died. They have an expression which seems to want to welcome the person who has left life. In the face of this description, it should be borne in mind that faith is not in any way science-fiction.

Death is a part of our existence. There are people who mask death, who paint it over, or who hide it, and there are others who accept it as it is. But to accept dying one must 'acclimatise oneself', to understand what will happen to us, and this should be done beginning with faith, hope and love, the ingredients which not only make it easier to accept this reality but in definite terms fill it with meaning and personal fulfilment. But what should we believe? What should we hope for? What should we love? These are three verbs which call on and worry all those who want to face up to this subject personally. The before and the after... will be strongly impregnated with meaning if these three categories are taken into account. The 'before' because it bears upon the daily life of the person in all his or her dimensions (functional-biological, psychological, social and spiritual), and the 'after' because *a priori* one does not know anything and the person is moving inevitably towards the final moment.

This integration of the here and now, and of the there and then, passes, as has already been observed, through believing, hoping and loving. To have faith in the fact that death is not the end of everything, to hope that something good will come out of all this, and to love because this is the most important thing there is in life. Furthermore, when the final adieu is spoken, love is really the only thing that remains.

JOSÉ GARCIA FEREZ,
Assistant Professor at the Faculty of Theology of the Pontifical University 'Comillas', Secretary of the Chair of Bioethics and Master in Bioethics of the same university, Professor of Bioethics at the Centre for the Humanisation of Health.

Dying in our Society: Philosophical and Ethical Aspects

1. Dying in History

Death is not only a biological fact: it is also a cultural event which is experienced and transmitted within the context of the collective imagination, in addition to being a political question, because it gives rise to the action of the state in a democratic and pluralistic society in which different ideas encounter and come into conflict with each other at the level of law. But the question of death, both at the level of definition and at that claimed at a personal level as being a right on commission, finds its meaning in that philosophical question which seeks to understand the complexity of the human condition, the meaning of its existing and its dying in the ambiguity specific to a society where values and anti-values intertwine and are in contrast with one another in dramatic fashion, such as the meaning of the potentiality of the object, technological efficiency, scientific progress and destructiveness, necrophilia, the planning and the decreeing of life, and its own and other ends.[1]

Death is an incomprehsible and indefinable event for contemporary man, above all else in the light of the aspired to omnipotence of biomedical technology. During the medieval period, in fact, it was suggested to health care workers, to family relatives, and to the dying person himself or herself, that an unbridled rush to forms of treatment in order to regain physical health was something to be avoided. The idea was rather that the dying person should be prepared to enter consciously into the spiritual dimension. In other terms, death was the epiphenomenon of an existential process, or better, a process of gradual dying. Dying was a *vera ars vivendi* in the sense that every moment of life had to be lived in an overall way in its fullness and in preparation for a new way of living within a metaphysical horizon: spatial-temporal life was a *carpe diem* for and in relation to spiritual life. Here the Anglo-Saxons distinguish dying as a process from death as an event. Physical human life is characterised by a teleologism, death, and by a *locus epistemologicus* as a point of ontological reflection, that is to say of being that is realised through living. Indeed, death is the characteristic element of this human realisation, in addition to being transcendental opening. In fact, both in the psychological domain, and in the philosophical domain death is the impenetrable destiny of mankind: it is the end of a terrestrial biography but also the potential expression of metaphysical freedom.

According to positive law, death involves the loss of every right and duty but not the, albeit unconscious, right to have one's own corpse respected. Furthermore, it can become a moment of the highest expression of the freedom of the giving of oneself to other people, as happens in the case of organ donation. With physical death the very process of perception and experience comes to an end, at least in the positivistic sense of acceptance, whereas in fact death constitutes the transfiguration of dying into historical living (that is to say living is dying, and dying is living) or into an eschatological dimension. In every historical age man has never feared death as an event but he has feared the process of dying both at the physical level (he fears pain, suffering) and at a psychological and social level (a sense of the removal of family affections, economic goods, etc). Such fears are removed at a human level by man and concentrated into death as an event, not least because this existential limit has always been increasingly modified and planned by modern technology (for example the development of medical resuscitation).

Philip Ariès[2] has identified four ways of living the event of dying to be found in human history, and they may be listed as follows:

1. The tamed death of man of the medieval age. Man is aware of his finiteness and his destiny in the form of death, indeed he experiences it as a natural event connected to the chronological age of each and every person according to a series of seasons of life: there is the age of birth (spring), of psycho-physical vigour (summer), of senile decay (autumn), and then the end of the terrestrial journey (winter). Aware of this cyclical nature of life, man awaited death with tranquility, supported and surrounded by his family relatives and acquaintances. This was a tamed death in the sense that it was not experienced in a blind way, but at the same time death was not an irrelevant existential event.

2. The death of oneself or one's own death: the man of the period which runs from the twelfth to the seventeenth centuries discovered that death was a self-limitation in relation to his own great ideals and plans. This awareness of oneself took place because the process of the socialisation of death itself de-

clined. Man was left alone with his cold rationality, at times without the support of faith, and discovered his existential limits. He perceived that the move was personal and could not be transformed by reason itself. The seventeenth century was the age of rationalism, of scientific discoveries, of trust in progress, which, however, was powerless to distance opposed natural forces – *eros* and *thanatos*, life and death. When this last came to prevail it left the subject in a state of desperation and fear. Fear above all else of being buried alive – the rite of '*conclamatio*' was evidence of this, a rite which involved, in conformity with the instructions expressed in the person's will, the corpse being addressed three times before being actually buried.

3. The death of the other person: in the eighteenth century, at the height of the Romantic regime, death was experienced as the loss of another person, and took the form of a reified character of social reflexes. Those who surrounded the dead person wept and exorcised death with religious practices (prayers, invocations) because their affective and relational possessions were being removed. This was a form of socialisation of death as a reaction to the personal diminishment of those who were linked; it was a kind of intolerance in relation to separation.

4. The prohibited death of the twentieth century: this was typical of the positivistic age and of the scientific discoveries of experimental medicine and biotechnology, elements that were able to make precise diagnoses which at times involved the prediction of death and had a notable prognostic value. Foreseen death worries people, frightens them, and as a result it was better not to talk about it, to keep it hidden or at least to conceal it not only from the sick person but at times also from his or her closest family relatives. In the light of medicine, death became a synonym for defeat, which was hidden behind a white sheet, a waiting room prior to removal, where it did not frighten other people, and in that loneliness and isolation what had happened was almost not noticed. Death became a personal fact where even every social and participatory demonstration was relegated to the so-called 'rites' of the funeral parlour. The very process of dying was increasingly less taken part in, with the dying person being entrusted to suitable institutions such as hospices, residences for terminally-ill people, and homes for the elderly.

These four approaches to death have now been joined by a new tendency:

5. The return of death, a development that is expressed at two levels:

a) Speculative interest. Interest in death involves different speculative domains (the historical, the anthropological, the psychological, the sociological, etc.) as a thanatological reaction to the removal of the denial or the ideologisation of death. The historiographical analysis of P. Ariès, mentioned above, is marked by an interest in the experience of dying and death as a personal, social and eschatological phenomenological event. This historian has transposed the reflections of American authorities on the subject onto the European context, and has emphasised the approach of constructing a taboo in relation to death which is characteristic of our age. The same conclusions are reached by the two historians, J. McManners[3] and M. Vovelle.[4] In the sphere of psychology, in Italy for example, F. Campione organised a university centre in Bologna concerned with studies on death and related questions and issues (for example mourning, suicide and euthanasia), an initiative which gave rise to the *Revista di Tanatologia* (Zeta). This author seeks to rediscover death by combating the thanatological inversion characteristic of modern man, who strives to remove and deny death by rationalistic paths, betraying dying as a way of living: death is a human reality, which despite the difficulties encountered in understanding it, belongs to existence and being in the world. In the sphere of sociology, N. Elias,[5] beginning with the tandem 'ageing/death' which is typical of our industrialised society, observes how death has become a personal fact, a solitary event even though protected by the institutions of the welfare state and anaesthetised by the advances of medical science, the expression of a process of the control of emotions and affections which is characteristic of the contemporary stage in which civilisation now finds itself: 'so removal, the atmosphere of ill-being that often today surrounds the final moments of life, are certainly not a help for people. Death conceals no mystery, opens no door – it is the end of the human creature. What remains is what has been given to other people and what remains in their memories. The ethics of *homo clausus*, of the man who feels that he is alone, will decay rapidly if we cease to remove death and accept it instead as an integral part of life'.[6]

b) Existential curiosity. Certain phenomena typical of our time form a part of the tendency which involves the removal and the denial of death. We are in the presence of an increasingly posed question about what happens after death: visits to clairvoyants, to mediums, paraphsychology magazines, religious movements which preach reincarnation, pre-death studies, and all the rest. A. Moody Jnr.'s studies in this area on 'ideal' or 'ideal' pre-death experiences are well known.[7] His research is interesting and indicative of the new interest in the event of death, although its results are debatable from both a scientific and a philosophical point of view. It is the case that a patient who is subject to pain and unbearable suffering can temporarily alter his or her percep-

tive and consciousness faculties as regards external messages and that during the internal processes of elaboration this can lead to errors in the process of decodification. In these cases, we are not in the presence of people who are dead in the bio-functional sense of the term, we are dealing here with clinical deaths, which are very similar to other physiological or pathological situations of the psyche such as dreaming, schizophrenia, hysteria and suggestion. What the 'dead patients' of Moody are referring to as reality is in fact the experiences of dying, that is to say instances which anticipate death, but not real death itself. Thus the results published by this author are extreme situations of experiences of dying which do not in the least provide or offer information about the life beyond our own. In fact, this renewal of interest constitutes another negative aspect of removal, that is to say speaking about death with a view to exorcising it rather than experiencing it in one's own consciousness as a natural fact of human existence.

Our society, instead, needs euristics of death and dying, and it is precisely this biological and biographical event and process that allows us to understand the meaning of living, the value of life, of illness, and of suffering: as a tendency of being towards overall self-realisation, towards making one's own action responsible, as well as one's own choices and their consequences not only for oneself but for each and every person. Cicero liked to argue that '*tota philosophorum vita commemoratio mortis est*', that is to say death should become a moment of reflection and of awareness about the limits to one's own human condition, to one's own actions, and, in addition, a rediscovery of the value of life.

Philosophical Thanatology and the Consciousness of Contemporary Man

In our secularised society there is no longer any space to reflect upon and speak about death. This is because the worldly culture of external beauty, of physical and economic well-being, of the discoveries of cosmetic surgery and cosmetic systems are able to mask every final reality. Our cultural world has given way to uncertainty and artifice rather than engaging in a positive appreciation of the naturalness and certainty of the vital human processes. The very language of dramatic encounter with death has been subjected to a taboo, and increasingly in obituaries the noun 'death' is avoided and replaced by sweeter phrases such 'has gone to rest', 'has gone on', 'has left us', and 'has disappeared' – we have before us a tendency to preach the death of death. Philosophers, in different fashion, have been less concerned about linguistic taboos and have dedicated a great deal of space to the question of death, its understanding and justification, in their rational speculations. In particular, they have been concerned with

the argument advanced by Martin Heidegger according to which 'living-for-death' is the authentic meaning of existence, but also that proposed by Soren Kierkegaard (1813-1855).

The works in which Kierkegaard dwells upon these questions and issues are many in number, and go from 'The Concept of Anxiety' to 'Diary', and on to the 'Three Discourses for Imaginary Occasions', which he published in April 1845. This philosopher sees in the modern world a widespread superficiality and widespread indifferentism in relation to the meaning of life, Christian values, and he perceives in death (indeed, in the thought of death) that propulsive element that can shake man out of his worldly torpor of daily life. In his work 'Next to a Tomb',[8] this philosopher does not seek to propose a invitation to learn how to die, nor does he suggest elements that can console us about death, rather he generates in the reader those reflections which lead him or her to a more authentic life, that make him or her understand that death can be a real and unique teacher. His methodological approach constitutes authentic maieutics by which to learn to live, to understand within the horizon of death the real meaning of life and responsibility towards oneself and other people. This is the 'thought of death' which ensures that man lives an existence which has the characteristics of seriousness and not those of vacuous fatuousness. He argues that 'the seriousness of death does not deceive because it is not death which is serious but the thought of death. If, therefore, you, my dear listener, adhere to this thought and in thinking it do not concern yourself with anything else than thinking about yourself, thanks to yourself this approach without authority will become something serious. To think ourselves dead in the first person is seriousness, to be the witnesses of the death of another person is a state of mind'.[9]

Kierkegaard argues that death is seriousness, not so much because of the external fact of the death of somebody else but rather because 'it can teach us that seriousness is in the internal, in thought; it can teach us that to look with melancholy or indifference towards what is external is an illusion... the seriousness of death is different from the seriousness of life, which so easily draws us into a deception'[10] through such elements as states of mind, feelings of piety, or memories, which vanish and make us forget about the seriousness of death and do not affect our lives, save where they immerse it and hide it in the depersonalism of daily routine. Death, Kierkegaard affirms, is the teacher of seriousness and it is the thought of death that points out 'the right direction in life and the right goal towards which to direct our journey. No bow allows us to be directed so much, no bow is able to impart so much power to the arrow, as much as the thought of death, which calls on the living, as

long as it is seriousness which bends it'.[11] The thought of death must not distract man and lead him to engage in the sensual pleasures and lose himself in daily routine, just as it must motivate him to involve himself in life without wasting the time that is available. Death for those people who live seriously is not a narcotic that inhibits, but a 'source of energy unlike any other, which makes us awake like no other'.[12]

Education in life, for that matter, must be based upon the existential reality and seriousness specific to the thought of death, employing the limited and finite instruments specific to uncertainty that are offered by human and historical contingencies. Kiekegaard maintained that 'the serious man is the man who is educated out of uncertainty to seriousness because of certainty... the pupil worries, in fact who does not worry cannot learn about this or that subject with all his or her soul, and in reality, also, the certainty of death is a subject to be worried about. The pupil who worries about it turns to the teacher of seriousness, and as a result death is not something that is frightening, although it remains frightening for the imagination'. Death, finally, is the most certain thing, but at the same time it is the only thing about which there is nothing certain; indeed, no man knows the exact moment when he will meet death. 'The certainty of death determines once and for all that the pupil enters seriousness but the uncertainty of death is his daily supervisor... Seriousness thus becomes living every day as though it was the last, and at the same time as though it was the first, of a long life'.[13]

Kirkegaard's criticism of those who tend to explain, and after a fashion also to justify, death is also of great relevance here: 'as regards death, one should not rush to acquire an opinion about it. The uncertainty of death is constantly and in all seriousness freely verified if the person who has an opinion really has this opinion, or if his or her life is an expression of it'.[14] In other words, this philosopher distinguishes between what death is in the opinion of intellectuals, and how they live death, in an analogous way to the harsh criticisms that Kiekegaard levels at Christianity. He makes a net distinction between 'knowing what Christianity is' (which is the easiest thing) and 'being Christians' (which is the most difficult thing). For that matter, in his work 'The Concept of Anxiety',[15] Kierkegaard had already defined death as planning towards Transcendence, towards 'the Other' who constitutes the end of possibility (of vagueness, of uncertainties). Death is the price to be paid for sin, and is the encounter of the individual with time and eternity. The anxiety of death has as its end transcendence itself.

For Martin Heidegger, as I have already observed, life has meaning only if it is finalised to death. In his work 'Being and Time', Heidegger considers the phenomenology of man. Being never reveals itself directly, in

an immediate way, but through the being of an entity (a man, a dog, a home, etc.). We can understand the nature of being by beginning with the being of a particular entity, and in removing from it what does not belong to it the being is unlocked from itself. 'But we give the name of 'entity' to many things and with different meanings. An entity is everything that we speak about, what we speak about, what we behave towards in one way or another. An entity is also what we are and how we are. Being is found in what is, in being in that way, in reality, in mere presence, in subsistence, in validity, in Being, in 'there is'. In which entity should the meaning of being be grasped? From what entity does the opening of being take its steps? Is the point of departure immaterial or does a specific entity possess a primary position as regards the approach to the question of being?'[16] The privileged entity by which to understand the meaning of being is man, who is able to pose to himself the question of being, and this is because he has a special relationship with being. For this reason, man is the entrance door to being, as long as our knowledge of man is error-free. This philosopher, in his anthropological analysis, identifies certain fundamental elements in man which are typical of his being, and these he calls 'existential'.[17] They are as follows:

Being-in-the-world. Here Heidegger means by world the set of interests, of concerns, of affections, of wishes, of forms of knowledge in which man is immersed. Man is always inserted into situations, and is thus called by this thinker 'Dasein', being, that is to say the condition of 'situationness' in which man finds himself every day.

Existence. Man in his situationness is not a static state but is projected towards the future, that is to say he is open to becoming something else. Every action is finalised to what man wants tomorrow. Thus existence is the possibilities of being of man, it is man outside of himself – such is the essence or nature of man.

Temporality. Man is an existent being because he is bound existentially to time. It is the temporality of being that generates time and not, *vice versa*, time which renders being temporal. Man is not stranded in being but in his real being he already finds himself beyond himself, projected into his future possibilities. In this sense man is existent because the expressions of situationness present with the luggage of past experiences are projected into the future – man is future. In bringing about these possibilities, man, therefore, begins from a situation of fact into which he is at the present time inserted, and in this sense he has been: the past presents itself as a static contingency of the present of man who projects realisable possibilities into the future. Temporality, therefore, unites existence (the possibility of future), actually being (the

present), and being deceased (past), and this constitutes the three elements of what goes to make up the structural totality of man.

To each of these three temporal states there corresponds three ways in which man knows:

– past, through feeling;
– present, through taking;
– future, through understanding.

Between Being-in-the world (first existential) and Existence (second existential) there exists a *clivus* of contrasts with possible forms of conditioning in the

expression of being. Gazing on Being-in-the-world leads man to stop in the past, whereas in polarising himself in existence everything is projected into the future. According to which conditioning tendency prevails in the life of a man (the meaning that he wishes to give to his life), he will either live a non-authentic or authentic life. Heidegger sees as constituting a non-authentic life that life which allows itself to be administered by situationness, by 'chatter', by being-in-the-world, by being concerned with things and anonymous mass relationships. The non-authenticity of life is dominated by anonymous mass relationships which level the expression of life itself and the aspiration to knowing. Whereas, in fact, authentic life is determined by the subject gradually, in line with an active definite plan, feeling the responsibility of an incessant appeal of the future, the only place for the realisation of his possibilities.

The aware planning and construction of a meaning to life can make it authentic, can open out its possibilities, removing it from the day by day character of the situation and from vagueness.

Man is an existential pro-ject, the actuation of possibility. If Being-here wants to acquire its authenticity it must take on its most specific possibility – death. The man who directs his existence towards death has an authentic life. Death, for Heidegger as well, is a personal fact – my life and my death belong to me because they are the ultimate possibilities of existence. Death is the objective of one's own existence. Man in his 'being-in-the-world', in his 'being-here', in his being 'thrown' into the world, in his 'being in a situation', is searching for the 'Being' hidden behind the daily 'care' employed in the use of things. Man thus moves towards truth as a revelation of what is hidden. In this search man finds anew the authenticity of 'being-here' if he directs his planning to death, the implicit end of which does not mean a 'being-at-the end' of being-here but being 'for the end'.[18] Before specifying Being-here as being for death, Heidegger restates that it is in the death of another person, who is near to me, that there is realised the first stage of understanding of the central phenomenon of existing, the move from the impersonal 'one dies' to dying as such. But for Heidegger 'nobody can take on the dying on another person'; we are near to the other person who dies but it is he or she who dies.

In 'Being and Time' Heidegger argues that death is a 'possibility', indeed it is the extreme possibility, the possibility of absolute possibility, which is an integral part of the constitution of the 'being-here' of man. The authentic Being-here foreshadows in an emotional sense its ultimate possibility in becoming a 'being for death'.

Just as in Kierkegaard the seriousness of the thought of death can bring about anxiety, even though this must not inhibit the person from constructing a responsible, aware and fulfilled life, so for Heidegger man becomes aware of his ultimate possibility of death and this is something that causes him anxiety because of the 'possible nullity of the possibilities of man and the whole form of man'. Man cannot withdraw from such a possibility without a denial of the character of his being. Death for man means the achievement of the Totality of his life. Death is possibility itself in relation to which the authenticity of human existence is defined. Authentic existence is existence that is anticipated in death, that takes on death as the most specific possibility of living. For Heidegger, being-here cannot be seen as a totality because it is influenced by a potentiality whose practicability belongs to the very way of being of human existence. This becomes 'authentic' only if it keeps its gaze fixed on the death which looms up upon it, on its own finiteness. Authentic existence requires, therefore, the planning and the foreshadowing of death. Human life becomes totality through death, which limits it, informs it, and preserves it from being made unnatural and disfigured.[19] According to Heidegger, death is no longer, as it is in the Catholic tradition, the beginning of a discourse about the life beyond this one, but becomes an opportunity for a discourse about life, and at a precise level an opportunity to characterise life in terms of its rooted finiteness.

In this radically secular approach, Heidegger rejects suicide and sees it as flight from commitment and planning. There can be no doubt that Heidegger's idea of death is in essential terms individualistic in character. However, it overcomes anxiety not through dialectical artifices but through exit from chatter, from the non-authentic, and from the artificialness of technological society.

The alternative to the empty results of Heidegger is the proposal of Christian philosophy, which does not confine itself to a mere inquiry into death, but through reason, through the paths of faith, it offers directions to man that free him from noetic anxieties and improve the quality of his existing. The faith proposed by philosophers is not oblivion in theological expressions but an opening up to truth that transcends the mere request for truth of reason.

Gabriel Marcel has expressed with extreme clarity the philosophical correctness of immortality by identifying in love and loyalty between two human beings the sign of ontological resistance to death and a propensity to engage in the lasting. 'The spirit of truth also has another name, which is still more revealing – it is the spirit of loyalty, and I am increasingly convinced that what this spirit requires from us is an explicit rejection, a precise denial, of death... To love a being means saying: you will not die! For me this... is an absolute statement'.[20]

To believe that there is a world beyond the uncertain future of this world is a risk, but to refuse this risk would prepare the way for a road that leads to the void and to a total loss of self. Death is no longer an enigma but a mystery, a truth greater than us but a truth which is not completely unknown to us, a truth that is grafted into the heart of life, which is destined for eternity. Specifically when face to face with the death of another person, faith can raise questions about the capacity to think philosophically, 'Faith does not fear the great questions of reason; it only fears the small questions, cultivated under the wounding dictatorship of banality. And it is great questions, instead, that at this point we so desperately need, even at the cost of finding on the outlying ring of faith, inhabited by reason, only small answers. It is in fact the great questions, in the final analysis, that render the small answers great as well'.[21]

2. Death: A Neuro-philosophical Question

The definition of death is a subject that does not only involve neuro-physiological scientific knowledge but also raises philosophical questions. It is a subject that involves to the full bioethical reflection: what is man, or, better, what is a person? When does a man die? What are the parameters to be used to define the person and as a result his or her non-person of the corpse? Should the person be looked for in ontological substantiality or in the qualitative substantialism of his or her function as consciousness? Does the basic anthropology to define the life of a person refer to the principle of the sacredness of life or to the utilitarian principle of the quality of life? Obviously enough, the utilitarian reference has the advantage of seeing as being dead, and thus to be eliminated, every subject who not only has lost his or her reason (a person in a state of coma; a demented elderly person) but also a person who possesses this function only at a potential level (the embryo, anencephalic people, the handicapped). Given that man is a fusion of matter (the body) and form (relational soul), that is to say that the physical dimension is linked with and supports the psychic dimension, in the event of death when the body ceases to exist as such, the physical activities also disappear. This definition of death safeguards the psycho-physical definition of man, and the measuring of the physical datum of death is determining in defining death as an integrated system.[22]

Three definitions of death prevail in the bioethical field, and they are as follows:[23]

a) *Cerebral death*, initially described as depassé coma in the famous publication of the Harvard Committee (1968).[24] Subsequently, the debate became more lively and scholars such as the German philosopher Hans Jonas defined death employing a cardiological criterion, seeing the death of the organism as the death of a whole, that is to say not only the necrosis of the encephalus but the disappearance of the Bichat triad, i.e., the cardiac, respiratory and cerebral function. Here it is argued that:

– in cerebral death what goes is not these functions but their capacity for spontaneous expression, thus a disappearance of a whole does not take place;

– the classic Cartesian definition is proposed again here, a distinction centring around the body-brain, *res extensa – res cogitans* dichotomy, rather than the identity of the whole organism being recognised;

– the definition of cerebral death does not belong to a philosophical interpretation but rather to a utilitarian orientation, of the taking of organs for the purposes of transplantation, bestowing thereby a false tranquillity on the consciences of health care workers to the effect that the person declared dead really is dead.

b) *Cortical death*. This definition, although it is based upon empirical data, has a quintessentially philosophical character, and is advanced first and foremost by scholars such as Veatch, Engelhardt, and Defanti. These authorities see the death of a person as the disappearance of the higher cerebral functions, such as the activity of consciousness, and the rational functions such as thought, social 'relationality' and its expression through language. Cortical death involves an inability to engage in personal acts and thus the person is said to no longer exist. Naturally, these acts are the expression of the activity of the person, that is to say they constitute the personality, and are not constitutive of the person himself or herself. This definition of death is very dangerous because it runs the risk of a person being declared dead when in fact he or she is not really dead.

c) *Cerebral death*. The principle of the unification and integration of the human organism is said to be found in the brain in an overall sense. Thus death

is to be identified not only with the death of the cortex (responsible for the higher functions such as the activity of consciousness) or of the brainstem (responsible for the homeostatic, cardio-respiratory, metabolic, etc. functions)[25] but of all

the brain. The concept of death based upon the death of the brainstem is a metaphysical concept (the capacity for integration), lying beneath the corresponding principle according to which everything is more than the sum of its constituent parts (for this reason death is not the ceasing of an activity or of a function of the human body but the ending of a person, that is to say the loss of that element that confers unity on the organism, i.e. the nervous system).[26] The medical judgement, instead, seeks to verify the absence of the vital functions, that is to say the decease of the person. This definition was accepted in Italy by the Comitato Nazionale per la Bioetica (the National Committee for Bioethics) of 1991, which defined death as the total and irreversible loss of the ability of the organism to autonomously maintain its own functional unity, something to be identified in the brain, brought about by 'organic cerebral damage that cannot be repaired, where artificial support has taken place in time to prevent or treat anoxic cardiac arrest'.

Criteria for the Determining of Death

Whereas the definition of the death of a person is a matter for philosophy, the determining of the ending of the unity of the integrated complex of a person is a matter for medicine. Carrasco De Paul maintains that 'the moment of death cannot be the object of a diagnosis because it is neither evident nor verifiable. As a result, the asynchrony between the dramatic instant of the separation of the soul (understood as the moment of separation of the rational form or integrating and integrated form of rationality) from the body, and the moment at which the event of decease is manifested (the state of disintegration), must be maintained. Technological advance may be able to reduce the space of time which divides the two episodes, but it is improbable that it will disappear entirely. To diagnose death means to verify not the detachment of the soul but the absence of signs of organised life'.[27] Our legislation in Italy deems a person to be dead when cerebral death (state of death) has been ascertained: the brain is the principle of the unification and integration of the human organism, and this is to be found in the brain in an overall sense. To avoid the manipulation and abuse of bodies in special states of life, and in an attempt to establish rules regarding scientific data with respect to the existing confusion between cerebral death, cardiac death, comas, and the persistent vegetative state, law n. 578 of 29 December 1993 – entitled 'norms for the ascertaining and the certifying of death' – defines death, in article 1, as 'the irreversible ceasing of all the cerebral functions' caused by primary irreversible damage to the brain and at a secondary level by cardio-circulatory arrest and the lack of a flow of blood to the encephalus with the consequent arrest of all its activities: a person is dead when his brain is dead.

C. Manni makes clear that death is not an instantaneous event but a developmental process which can also precede by a great deal the complete necrosis of the organism. It is the moment at which there is recorded the irreversible loss of the integration and co-ordination of the physical and mental functions of the body, a moment generally defined with the term 'brain death', and a moment suitable for the removal of organs for the purposes of transplantation. In order to avoid misunderstandings connected with this term, it is more exact to speak about 'encephalic death', that is to say that condition when cell necrosis is extended to the whole of the brain. Other forms of brain death, such as that of the brainstem (the criterion employed in the United Kingdom for the diagnosis of death on a neurological basis) or of the cortex, are completely equivocal and generate dangerous forms of abstentionism in relation to people who are still alive.[28] This clarifying observation can come into conflict with those currents of thought that wish to describe physical death as the loss of some, albeit important, capacities of the patient, such as takes place with the death of the brainstem or the cortex, promoting thereby arguments which support the pro-euthanasia movements. Thus cerebral death should be distinguished from irreversible coma because in the latter clinical situation neurons still exist which continue to function, and thus the subject is not in fact dead. In the case of cerebral death, instead, all the cells of the brain have been destroyed.

Parallel with the concept of encephalic death, some criteria by which to ascertain such death have been drawn up. These criteria have been incorporated into sets of legislation in order to govern this very important area.

The concrete diagnostic ways by which to document the irreversible ceasing of the encephalic functions were laid down in specific fashion in the decree which implemented the law of 14 April 1994.

In the case of cardiac arrest an assessment made through the use of an electrocardiogram for at least twenty minutes is sufficient. After this period, in fact, we can be certain that the anoxia has produced irreversible and total alterations at the level of the central nervous system.

In subjects affected by encephalic lesions who have undergone attempts at resuscitation, the certain diagnosis of death requires the simultaneous and protracted registering for at least six hours of certain specific clinical-instrumental signs. These have been listed by the National Committee for Bioethics as the following: a state of coma which does not respond to external stimuli; ariflessia tendinea of the skeletral muscles linked to the cranial nerves and thus the absence of brainstem reflexes (photomotorial reflexes, of the corneas, oculoencephalic or oculovestibolary reflexes, of the pharynx and the trachea); muscular atony; the absence of cerebral electric activity measured through EEG registration, and the absence of spontaneous breathing.

Conditions which could lead to error must be excluded (artificial hypothermia, substances which depress the central nervous system, endocrinal pathologies...). In children under the age of five, twelve

hours of observation are required; in children under the age of a year twenty-four hours of observation are required.

At the present time sophisticated machine examinations are able to confirm the accuracy of the diagnosis of cerebral death in an even shorter period, demonstrating in an unequivocal way the absence of cerebral circulation and thus that the blood cannot reach the cerebral parenchyma. First, there is cerebral angiography: in normal conditions the blood flow is equivalent to 50ml/100 gr. of tissue/min, and when this level

goes down to 15ml/100gr of tissue/min we are in the presence of the death of the whole of the cerebral population. Then there is the Doppler flowmeter, cerebral scintigraphy with Tecnezio 99m, and the SPECT (computerised tomography with the emission of individual photons).

The precise relationship between the death of the organism, encephalic death, and the death of a person is very far from being clear in all respects. If on the one hand one should clearly avoid transforming the affirmations of science into metaphysical realities, on the other in a realistic gnoseology the understanding of the human composition cannot depart from the supports offered by the empirical sciences. From a strictly practical point of view, we can, however, adopt the observations made on this subject by the 'Charter for Health Care Workers': faith and morals accept these findings of science. However, they demand of health care workers the most accurate use of the various clinical instrumental methods for a certain diagnosis of death so that a patient is not declared dead and treated as such when in fact he is not dead.[29]

Given that from a physiological point of view the encephalus carries out two important activities: the working out of the contents of consciousness (the cortical area), that is to say awareness of one's own being and existing in relation to the surrounding (physical, relational) environment on the one hand; and homeostatic (the encephalic trunk) activity, which in addition to regulating the state of being awake also has the function of relating and adapting to the environment of the person (temperature, blood pressure, metabolic activity), on the other, *the diagnosis of death*, according to Italian law, involves the demonstration of irreversible damage to the whole of the encephalus, which has to be so damaged as to eliminate every doubt about the possibility of life. The diagnosis of death is carried out by the medical doctor treating the case, who generally is a resuscitation specialist, and involves an etiopathogenetic definition of the damage, that is to say an exact diagnosis of the malady which has caused cerebral death. Once the diagnosis of death has been carried out, the resuscitation doctor tells the health authorities that there is a potential donor so that the *medical committee engaged in the ascertaining of death* can be appointed. These health care specialists have to be employees of a public structure and must not be members of the team responsible for the removal of organs or the team responsible for the transplant. They are: a legal doctor or a doctor of the health care authority or a anatomopathologist, that is to say someone who knows about the legal rules that apply to transplants. In addition, an anaesthetist doctor, a neuropysiopathologist or a neurologist or a neurosurgeon has to be present who is able to correctly read the print-out of an electroencephalograph. The length of the period of observation in order to ascertain death is six hours in the case of adults and children above the age of five, twelve hours for children between the age of one and five, and as much as twenty-four hours for children under the age of twelve months. The simultaneous presence of a state of unconsciousness, an absence of reflexes on the part of the trunk, and cerebral electric silence as demonstrated by an EEG, at the beginning, the middle and the end of the period of observation, allows the certification of the presence of death. The medical committee appointed to ascertain death must, after the relevant period of observation, confirm the diagnosis of death formulated by the medical doctor who has treated the case,

and whatever the case will engage in its activities from the beginning of the observation: the principle of shared responsibility and the need for unanimity will allow the drawing up of a statement as regards clinical and legal death. Thus, death is identified with the death not only of the cortex (responsible for the higher functions such as the activity of consciousness) or of the brainstem (responsible for the homeostatic, cardio-respiratory, netabolic, etc. functions) but of the whole of the brain. This definition conforms to that established by the National Committee for Bioethics of 1991, which defined death as the total and irreversible loss of the ability of the organism to autonomously maintain its own functional unity as identifiable in the brain, brought about by 'irreparable organic cerebral damage, where artificial support took place in time to prevent or treat anoxic cardiac arrest'.

3. Problems in the Definition of Death

We will now take into consideration certain attempts to achieve redefinitions of death that are based upon ontological foundations, that is to say in terms of the loss of personality or personal identity, following the loss of the neuropsychological structures responsible for consciousness and cognition. The ontological formulations here are unsatisfactory at a theoretical level, and indeed the ontological and biological formulations are not in competition with one another – the death of the cerebral trunk, in fact, also involves the loss of consciousness and cognition.

Ontological and Biological Interpretations

Awareness of the philosophical problems implied in the definition of cerebral death has led to discussion about the criteria to be employed to determine the loss of personality, and to certain people proposing the loss of personality, or of personal identity, as a valid parameter for determining death. The definitions which refer to the loss of personality have been described as ontological definitions[30] and placed in opposition to the biological definitions expressed in formulations which refer to the brain as a whole or to the cerebral trunk. The supporters of the definition and determination of death based upon ontological criteria refer to the loss of the higher cerebral functions of subjects in a persistent vegetative state and various forms of anencephalia. At times in this context ambiguous and out of place synonyms such as 'neo-cortical death' or 'pallic syndrome' are employed. In 1988 Smith argued in favour of the ontological definition of death and described the benefits of such a definition in the obtaining of organs for the purposes of transplantation.

The criterion of neo-cortical death is said to have the advantage of increasing in a significant way the availability of, and access to, transplants because patients (including those suffering from anencephalia) declared to be dead on the basis of the neo-cortical definition can be conserved biologically for years rather than a few hours or days as is the case with total cerebral death. This is said to offer the possibility of parts of bodies or the bodies of neo-cortically dead people being donated and conserved for the purposes of research over the long term in organ banks, or for other purposes such as pharmacological tests or the production of biological compounds.[31] The supporters of these ontological theses have even sought to describe the minimum qualities that are necessary in terms of psychological faculties to define the personality of the subject. The loss of the higher cerebral functions implies the loss of the continuity of the psychic processes, and thus a redefinition of cerebral death must stress the loss of personal identity. The ontological definitions attribute no importance to the persistence of other functions such as spontaneous breathing or the heart beat. The neurologists and philosophers who support the thesis of cerebral death refer to the higher or lower parts of the brain, which are responsible, respectively, for the cognitive and integrating functions. The ontological definitions for the most part concentrate on the former whereas the biological definitions address themselves to the latter. Amongst neuroscientists there is agreement on the fact that such 'higher cerebral' functions such as consciousness or cognition cannot be mediated rigorously by the cerebral cortex but it is probable that they constitute the result of complex inter-relations between the cerebral trunk and the cortex. The higher brain controls movement and language. Its action involves the contents of consciousness (covering in a broad sense the sum total of the cognitive and affective endowment of the individual). The contents of consciousness must be distinct from the capacity for consciousness, which is determined by the structures of the cerebral trunk. The higher parts of the cerebral trunk activate the cerebral hemispheres and are re-

sponsible for the generation of the faculties of psychological consciousness. Despite the fact that the capacity for consciousness (a function of the cerebral trunk) does not correspond to the contents of consciousness (a function of the higher brain), the pre-condition of this latter is fundamental. If the function of the cerebral trunk did not exist, there would not be an affective life, a cognitive life, thought activities or feelings and social interaction.

Gervais maintains that the 'permanent absence of consciousness' is the 'yardstick of death in man',[32] that is to say she defines death on the basis of the ceasing of the neo-cortical functions, even including newly-born victims of anencephalia and patients in a persistent vegetative state. This author has in mind neo-cortical death (a neuropathological concept) and the persistent vegetative state (a clinical concept), even though the first concept is never defined in a clear way. Indeed, the parameters corresponding to the concept of neo-cortical death require a flat electroencephalogram, whilst the patients in a persistent vegetative state who meet this requirement are few in number. Neo-cortical death is a very rare variant of the persistent vegetative state given that a large majority of these kinds of patients have not been subjected to hypoxic or ischemic injuries of such gravity as to produce a flat electroencephalogram. This writer criticises the formulation centred around the encephalic trunk because it is from the outset based upon biological considerations.

The formulation which centres around the cerebral trunk has also been criticised by other supporters of the ontological position. Green and Walker[33] argue that psychological continuity, brought about by the functioning of the higher brain, is needed for the maintenance of personal identity. Thus for these authors the continuity of personal identity is the defining parameter of life in man. For this reason, death is said to be the loss of the psychic function. The loss of the capacity to engage in psychic activity, when cerebral death deprives the body of its psychological traits, is when death is said to take place, not because of moral or biological reasons but as a result of what are mere ontological factors. It should be observed that there is nothing in the reference to ontological factors that can invalidate the formulation of death which centres around the cerebral trunk.

The concept of death which centres around the cerebral trunk necessarily involves the loss of all the cognitive functions and is compatible with the criteria of personality specific to the ontological definition: with the death of the cerebral trunk there is neither the capacity for nor the contents of consciousness. The divergences between the ontological and the biological formulations lie in the status of the residual functions, when, that is to say, the damage is limited to the higher regions and most of the cerebral trunk is, instead, still intact. The diversity between the two formulations has been acutely described by A. Earl Walker.[34]

Some people have affirmed that a person with a complete lack of intentional reactivity, but who is still able to breath and to maintain certain spinal reflexes or reflexes of the cerebral trunk, should be considered in legal terms to be dead. Yet, these individuals, who vegetate without showing any sign of recognition of or response to the environment, obviously do not possess a dead brain. It is mere conjecture that the level of functional activity mediated by the cerebral trunk and the spinal chord is sufficient for the capacity to recognise and react to the environment on the part of the individual. Anencephalic babies, who are born without brain matter above the cerebral trunk, are able to move, to makes certain movements with their arms and legs which appear to be intentional, and to react with elaborated motor responses. However, the life with which these babies are endowed for a short period is of a completely different quality from that of the life of adult human beings, although the question remains whether it is very different from that of a normal newly-born child.

The existence of differences in quality of life does not permit the redefinition of death: variations in quality of life are expressed in forms of being alive and with a continual function of the cerebral trunk there can be observable and recordable, although not intentional, reactions.

The Vagueness of the Concept of Personal Identity

The arguments adopted to define death in terms of personal identity often perceive an 'essence', whose loss brings about the loss of identity. The personality is seen as the manifestation of the specific potentialities of the person and thus the personality is a category or predication, even though not the most important one, of the personal but not unique substance. The arguments regarding personal identity are distinctly vague, and with respect to cerebral death have generated undoubted confusions between the death of a person and the death of the body of a person.

Personal identity, that is to say personality, is a quality near to others such as the spirit, courage, the will, the heart and the soul, all of which are attributed to a human being because of social conventions and not with reference to the physical structure of a subject. It is precisely because the personality is connected with the complex of relationships and legal and political approaches expressed in social life that there is disagreement about the determination of the moment at which a being can become a person or cease to be a person. Catholic theolo-

gians identify the origins of personal identity in conception because it is potentially present, whereas some philosophers locate its emergence in a much later stage of development in childhood. In the view of Kushner,[35] the personality is acquired and develops only gradually during the course of the development of the foetus and the child. The process of becoming a person is long and even at birth the newly-born child has only some characteristic traits of the adult personality, such as desires, wants, frustrations and feelings. Time is needed for the development of the more complex faculties during the course of the interaction of the child with his or her psycho-socio-relational environment.

In a criticism of the report of the Harvard Committee (the Ad Hoc Committee of Harvard Medical School, 1968), Hans Jonas[36] identified in the document a reproposal of the brain-body dualism where irreversible coma is adopted as a concept of death. But the observations made by Jonas are even more effective if they are applied to some of the contemporary theories about personal identity.

It seems to me that behind the proposed definition of death, quite independently of its evident pragmatic motivation, a curious return of the old soul-body dualism is concealed. This has now appeared as a dualism of the brain and the body. In a similar fashion to its predecessor, it argues that the real human person is made up of (or represented by) the brain, of which the rest of the body is a mere instrument. For this reason, when the brain dies something occurs which is along similar lines to the giving up of the soul – what is left are 'mortal remains'. Now, nobody will want to deny that the cerebral aspect is decisive in defining the human quality of the life of the organism that is man. This was the meaning of my position when I laid stress on the fact that the irreversible and complete loss of the cerebral functions should not authorise us to delay the death of the rest of the organism, the loss of which is the natural consequence of that loss. But to deny that the extra-cerebral body is an essential component of the identity of the person is no less exaggerated in the case of the brain than it was in the case of the conscious soul. The body is solely the body of this brain, and of no other. What is subject to the central control of the brain, the corporeal organism, is so characteristic of my person, it is 'mine', it is unique for my identity (one thinks of fingerprints), that it cannot be exchanged, like, indeed, the same brain which controls it (which is in its turn controlled). My identity is the identity of the whole organism, even though the highest functions of my person lie in the brain. For this reason, although the body of a subject in a state of coma still breathes, has a pulse, and functions, albeit with the help of technology, it must be seen as that which remains of the subject, and as such it still has the right to that inviolability that the laws of God and men have accorded to such subjects. This inviolability means that it cannot be used as a mere instrument or tool.

One of the most evident anomalies in concepts of life which centre around the person is that their supporters do not consider the distinction between the absence of responses to the environment specific to the death of the cerebral trunk and cases where the damage is limited to the higher parts of the person's brain. Most of the versions centred around the person refer to the mere absence of experience, to the lack of consciousness and of cognitive capacities. But it is not clear whether in determining death this loss of psychic reactivity to the environment has a greater importance than other deprivations. It is simply assumed that all that counts is the interruption of psychic continuity.

Some societies attribute to psychic continuity more importance than others. In addition, also that which constitutes the loss of psychic continuity presents itself as being culturally relative. The importance given to psychic continuity (the capacity to take initiatives) is the result of the cultural context belonged to, and as such has a spatial-temporal relativity. If this last was raised to the status of an exclusive criterion, a medical doctor who practices in a multi-cultural social context, something that is common in today's society, would find himself face to face with almost insurmountable problems at the moment he decided whether to proceed with resuscitation or not. But even if he were able to determine, with a satisfactory level of precision, that personal identity had been lost, that 'X is no longer with us', this would still not be a good reason to formulate a diagnosis of death. It would mean at the most that 'X is no longer with us in the sense that he is no longer what we knew him as'.

The definition of death centred around personal identity encounters difficulties in extreme cases such as anencephalics or those people affected by grave dementia. The similarities between a persistent vegetative state and grave dementia are much closer than those between the loss of the function of the cerebral trunk and a persistent vegetative state. There are in addition clinical objections to a diagnosis of death where there is an ongoing functioning of the cerebral trunk. It is still not clear if fragments of consciousness or of awareness can be mediated by the sub-cortical structures. In particular, it is difficult to demonstrate the total absence of sensitivity when there is a lasting functionality of the cerebral trunk.

Whilst it is relatively simply to diagnose the death of the cerebral trunk, the same may not be said for death conceived in terms of the loss of the higher functions. The diagnosis of a persistent vegetative state can present certain difficulties, and the problem of the diagnosis of

the absence of self-awareness should not be underestimated. Differently from clinical tests for the death of the cerebral trunk, which is an unmistakable phenomenon, the tests for self-awareness can have different results. Some patients in a persistent vegetative state show a considerable number of organised behavioural responses in reaction to sudden or harmful stimuli. Nearly all of them reacquire the cycles of sleep/being awake: they display facial expressions denoting interest and some even display emotional fluctuations with occasional tears or smiles of an infantile kind in response to non-oral stimuli. Some move their eyelids regularly in the face of a visual threat, open or close their eyes in reaction to sudden noises, or display reflexes involving groping or sucking.

For the health care workers looking after these patients, and the family relatives of these patients, these behavioural expressions are indicative of the continuation of life and suggest that residual levels of self-awareness cannot be excluded with certainty. The clinical-instrumental parameters to establish the irreversible loss of consciousness require more accurate definitions. Despite the fact that the cases of recovery from persistent vegetative states are rare, the residual possibilities following damage confined to the higher regions of the brain require clinical research and philosophical reflection for us to be able to issue a diagnosis of irreversible absence of self-awareness.

Stanley[37] has affirmed that 'there is at the moment no simple test which is valid at a practical level for the persistent vegetative state' but 'there is certainty about the non-reversibility of the death of the cerebral trunk, a certainty which, instead, is lacking in the case of decortexation'.

The prognosis of the death of the cerebral trunk and of a persistent vegetative state, respectively, have similarities only during the initial period. The death of the cerebral trunk can be brought about with absolute precision within a few hours or a few days at the most. But in the case of a persistent vegetative state the prognosis of the non-retrieval of cognition and other intellectual functions cannot be determined with even a low level of certainty, something, instead, which can only be achieved much later on in the development of the condition of these kinds of patient.

An unbridgeable disagreement does not exist between the ontological formulation of death as advanced by Gervais and the formulation centred around the cerebral trunk, in the sense that both place emphasis on the irreversible loss of consciousness. But differently from Gervais, the supporters of the formulation centred around the cerebral trunk place equal stress on the loss of the moneostatic capacities, such as breathing and the heart beat, that is to say of all the organismic functions. The thesis of Gervais[38] on human death, as a state of 'permanent unconsciousness', implies the inclusion among the list of dead people of those subjects in persistent vegetative states and anencepahlics as well.

The Problems of Neo-Cortical Death

If we want to assess the respective merits of the formulation of death centred around the cerebral trunk and that centred around the higher brain, and their consequences in terms of the removal of organs for the purposes of transplantation, we have to take into consideration three ethical and philosophical positions.

The first position advances the thesis that the death of the cerebral trunk constitutes the death of the person. The supporters of this thesis argue that once the criteria for the death of the cerebral trunk have been met, there are no further ethical obligations of the kind that should be applied to a person who is still alive.

The second position holds the view that the death of the cerebral trunk constitutes the death of the person but not necessarily the death of the body, which could go on 'living' with the help of sophisticated medical technology. in this sense, a diagnosis of the death of the cerebral trunk does not determine death but merely indicates that the individual belongs to a category of beings whose death is permitted. This position should be rejected because the death of the cerebral trunk meets all the necessary and sufficient conditions for there to be a diagnosis of death.

The third position puts the death of the cerebral trunk and a persistent vegetative state on the same level, and as a result no ethical problems present themselves with regard to the classification of the two conditions of death in question. The proponents of this view argue that the capacity for moral action is linked to the integrity and the continuity of personal identity, which in turn depends on the biological substratum responsible for the maintenance of the cognitive functions. For this reason, a corpse and a patient in a persistent vegetative state are not capable of relevant moral actions. Furthermore, it

should be observed that the inability to begin a morally significant action, or even to react or to be aware of such action, is not a reason to exclude a subject from belonging to the moral community or to deny the right to morally significant

attention. In the view of Gillett[39], the ability to express and develop personality depends in a crucial way on the in tact functioning of the brain (and in particular those areas of the brain which are most gravely damaged because of cases of trauma or anoxic ischemia) which allows the individual to interact with other people and with the surrounding world in a rich and complex way. Once this crucial condition has disappeared, we are justified in thinking that his body can no longer be considered as the location of that activity we call the expression of personal identity. If the brain has stopped working and there is no possibility that it will return to a level of working which can sustain such activity, then his or her freedom as a person endowed with a body has been destroyed.

This involves the upholding of the right to euthanasia, and the extension of the definition of death to persistent vegetative states and all the other cases where it is believed that the conditions for an ethically relevant life do not exist. Lamb[40] argues that whereas there is a clear distinction between the criteria for euthanasia and the proposal of criteria for the diagnosis of death, there is a sense in which this distinction can lose its relevance. If the criteria in both cases are based upon the loss of meaning and the ability to appreciate life – the loss of personality – then once it is affirmed that these criteria have been met, it is of little importance what description is applied to the set of actions (or omissions) that lead to the extinction of the residual life functions. In these cases, in fact, the crucial border is said to be crossed at that moment at which life is said to have lost its meaning.

Rachels[41] argues that it is necessary to make a net distinction between being alive in a biological sense and having a life in the social and moral sense of the term. In his opinion, being alive in a biological sense is in relative terms not very important. Life, in contrary fashion, is meaningful because of 'its aspirations, decisions, activity, projects and human relationships'. Once life has been lost, in these terms, being alive (such as a patient afflicted by Alzheimer's disease) is of little moral importance. The approach adopted by Rachels is of a clear euthanasia-inspired and eugenic stamp. It raises certain doubts: what do we mean by meaningful, and meaningful for whom? According to what social rules? Meaning is such because it refers to a fundamental essence – life. The meaning of life cannot be a reason for engaging in a personal or social assessment, it should merely be appreciated for its essentialness. But against this thesis it should be emphasised that the criteria which meet the biological concept (the death of the cerebral trunk) are precise and objective, whereas the criteria for having life are vague and subject to a variety of social and personal interpretations. Indeed, Gillett defines being alive in an 'ethically interesting' sense.

Gillet[42] on this point makes the following observation: 'When the body of a person has fallen into a state where he or she is not able to sustain anything beyond his or her life as a person, we are completely right in saying that his or her soul has separated from the body, whatever our metaphysical beliefs and convictions may be... Without 'getting mixed up' in definitions of death, we can affirm that this person is not alive in the 'ethically interesting' sense of that term. Once this decision has been taken we no longer have before us a person who is a patient to be treated but a body in which our ex-patient is no longer interested. This is a social utilitarian disengaged approach...'

Gillet is clearly working within a Cartesian dualistic conceptual framework in seeing the loss of certain structures connected with consciousness as constituting the criteria for the definition of death, or rather of the non-meaning of living. But the exact description of the structures involved and the size of the damage which has to be undergone are not easy to formulate. Furthermore, why such primary ethical importance should be given to consciousness is not clear. Although connected with ethically significant interactions, such as intentional behaviour and responsibility, it does not constitute the totality of what has ethical importance. Indeed, one may observe that the person who is weak and without help generates in others a need for respect and help.

In his observations, Lamb observes that there are many social contexts in which one could invoke the criterion that meets the concept of 'no longer being alive in an ethically interesting sense', but one cannot reach a level of precision and certainty such as to justify the employment of these criteria in situations in which it is a matter of deciding whether to authorise the suspension of treatment or the removal of organs for the purposes of transplantation. To extend the definition of death to the point of including decortexation (or the loss of personality in this sense) compels us to address ourselves to a large number of implications that are contrary to current clinical practice and to widespread public attitudes, including the implication according to which all those patients who are in a persistent vegetative state are indistinguishable in an ethical sense from corpses. The affective and cognitive components of consciousness can be essential for a meaningful and pleasurable life but they are not necessary and sufficient conditions for a diagnosis of death.

To summarise: the idea of

cerebral death is very far from being universally accepted, although it is the subject of many definitions and diverse criteria regarding its ascertainment. We may remember above all, because of the influence that it has had, the Report of the Ad Hoc Committee of the Harvard Medical School of 1968 and 'A Proposed Uniform of Death Act' of the President's Commission of 1981.

The English neurological school argues, in fact, that for there to be cerebral death, the death of the encephalic trunk is sufficient. However, in coma produced by primary injury to the trunk, there is often the persistence of visual potential fluttering and spontaneous cortical electrical activity – the absence of the working of the rest of the encephalus is the result of the lack of input from the trunk and not of an intrinsic functional deficit.

In a rare pathological situation, the 'locked-in syndrome', there is a partial injury to the trunk, and the person, although he or she is not able to communicate with the external world, remains to a certain extent conscious and in truth is like a prisoner, locked in himself or herself.

The death of the encephalic trunk alone is therefore insufficient for a declaration to be made to the effect that the whole of the organism is dead.

Other authorities, above all Americans, identify cerebral death with cortical death, even in the presence of integral or working cerebral trunk structures. In this clinical condition, named 'persistent vegetative state', or apallic coma or coma vigil, there remain active the capacities for the (central) homeostatic regulation of the organism, as well as the capacity to carry out the life functions in an integrated way, including autonomous breathing: there is not, therefore, the total and irreversible loss of the functional unity of the organism.[43] Stress should also be laid on the fact that this state is not always irreversible and that there are cases of a partial recovery of relational life. The underlying idea of this position is that the individual is a person only if he or she can carry out certain functions held to be characteristic of man, such as being self-aware or responsible. This discrimination between human beings in terms of their performance, although one is dealing here with expressions of typically human performance, is unacceptable.

The position which requires the irreversible loss of all the encephalic structures seems to be more persuasive and is in harmony with an overall vision of man as a psycho-physical unity in which physical and mental functions are distinct but interconnected expressions of the person. For this reason, it would be preferable to translate the English expression 'brain death' into Italian not with '*morte cerebrale*' ('cerebral death') but with '*morte encephalica*' ('encephalic death'), with a precise reference to all the encephalic structures and not only to the brain alone.

Concluding Observations: the Personalist Position

The human person is a fusion of matter and form,[44] and thus should be seen in his or her material component (a biological being) and in his or her spiritual form (or relational-rational form or a being being). Man lives this condition of incarnated existence – man is incarnated spirit.

Death cannot be described solely in terms of the organismic decomposition of living matter, but above all else it should be described in terms of the destruction of human existence, that is to say the eclipse of every expression of personal presence in this world.

Death is human precisely because of its spiritual-formal character, otherwise it would be a process of material corruption. Only in man is there a mortal being: in every other entity because of the lack of a rational form it is destined to perish (a plant, an animal). Heidegger argues that 'men are mortal. They are mortal because they can die, To die means to be capable of death as death. Only man dies. Animals perish. They do not possess death because death is neither ahead of them nor behind them. Death is the casket of nothing... The mortals are now called mortal not because their terrestrial life finishes but because they are capable of death as death'.[45]

Ramon thus concludes that 'every material substantial entity, because it is composed of primary matter and substantial form, is subject to corruption, that is to say to substantial mutation: separation of the substantial form (of a rational nature) from the primary matter. The material causes modify the accidental properties beyond the limit, making them incompatible with the substantial form through new substantial forms. Man is man because of the human substantial form: the spiritual soul; a corpse is not a man because it is informed by another substantial (non-rational) form which is not the substantial (non-rational) form of man; the substantial form has separated from the primary matter. Death is the crisis of the substantial union that constitutes each and every man, and it is painful because the body is co-natured with the spirit'.[46]

Death is thus a substantial ongoing event, that is to say a substantial mutation that limits two states: the preceding and the subsequent substantial entity. This is why death cannot be defined as the process of dying or the state of a corpse, but

rather as an instantaneous event where the material causes modify the accidental properties making the substantial union impossible and bringing about the rise of a new entity with new substantial forms. The human body is not a material objectivisation connected to a spiritual form but a 'subjectual' body, that is to say a body hav-

ing a psychic character which links it to the world in a particular relationship specific to human subjectivity. Indeed, the subjectual function of the body through its form expresses the existential and human condition. Death destroys not only the biological component (the body) but also the formal component, that is to say its personal and relational existence. The body is the 'subjectuality' of the rational dimension, that is to say the mediation of any expression and realisation of man in the world. From these premises one understands the dramatic nature of death, because it represents the dramatic end of human existence, because it is detachment-separation from the human world (=body), from its psychic form. The dramatic nature of the separation of the form from the body, however, opens up a horizon of immortality; at a phenomenological level the rationality is inserted into the temporality of history and becomes immortal; at a theological level the eschatological dimension emerges from transfiguration and the resurrection. Thus the human soul (the human substance) has the characteristic of immortality. The goals of thanatology are not those of assessing whether the body is dead but whether the whole of the man is dead, that is to say the human being in his or her integrity or unitive tendency as spirit in the world. For this reason, to ascertain and certify death from this point of view means to affirm this irreversible and total separation of the spiritual form from biological matter, and as a result patients in a state of coma or in a persistent vegetative state, where they continue to conserve their human form (or human substantiality), cannot be placed on this same level. The corporeal dimension is not only responsible for being in this world with its personal form but it is subject to being-for-death because material causes determine that limit of incompatibility with the substantial form and thus the disappearance/appearance of a new substantial entity – the dead corpse.

4. Ethical-Philosophical Problems Connected with the End of Life

We have already emphasised how in contemporary society the meaning of the event of death has changed, not only at the level of experience but also at the level of epistemological argument. This is due to the change in the paradigm within which death is interpreted and the difficulties associated with the definition of death in the legal-medical sphere (cardiac death, cerebral death, cortical death). Cultural contexts and epistemological models have favoured divergent forms of social behaviour, from the removal of the problem to scientistic reductionism which does not respect the spiritual or non-biological component of man, and on to ideological and pseudo-religious expressions which conceal this reality, taking advantage of the weakness of the mental states of their adherents. These attitudes, which are spread far and wide by the mass media, have helped to disseminate states of uncertainty and insecurity as regards the methods and instruments by which to ascertain death, elements which are reflected in a low level of organ donation and the upholding of the right to euthanasia. The alteration in the paradigm of reference for the meaning and experience of death can be encountered at – indeed, is to be attributed to – three levels, which may be listed as follows:[47]

1. The socio-cultural level. Here we encounter the affirmation of rational-secularism and the suppression of the eschatological dimension specific to Christian faith. Death as a moment of moving on from one life to another comes to be experienced as something which concludes life. The worldly empirical daily experience has imposed itself as the sole ontological horizon of man – there is no hope that transcendence exists.

2. The availability of life. Life used to have a sacred character which saw man as the steward of the life entrusted to him, and God was the only Being who could govern life. The denial of God, individualism with its denial of every form of social relation, and dominating subjectivism, have all fostered an experiential solipsism with a consequent upholding of personal rights rather than the social rights characteristic of a state based upon the rule of law.

3. The ontological horizon. Man as a being in the world 'being here' is aware of his finiteness and his mortality of 'being-for-death'. This awareness is the authentic experience specific to the human being but it is absent in every other living being. Man is aware of his death and sees it not only as a biological transformation but as human death. Authenticity is

taken on as a norm corresponding to this human awareness. Authenticity is awareness of the specific limitation of man who does not have any other meanings than those which are intrinsic to him. As a result, death is the possible experiential limit of man, beyond which there exists an emptiness of possible meaning and sense. It is an elimination of meaning and of the symbolic realities which have so far been valid, such as death as moving on, the life beyond, eternity. In this axiological horizon a good death cannot find space because the attribute of sense is always referred to something that has a temporal and spatial dimension, that is to say that which has a certain continuity of meaning. With death time and space no longer exist, and thus its only reference is the non-being specific to elimination, non-authenticity. Thus the non-sense of the expressions regarding a good/bad death, which are not authentic according to the approach of the secularist, and which cannot leave any space to the dignity of dying.

Obviously enough, the attribution of dignity to an action implies an ethical reference that includes responsibility, capacity, and awareness in relation to stewardship. The consequence of this argument could not be anything else than of a clear utilitarian character, as indeed are their secondary affirmations: prenatal life, the life of the mentally handicapped etc. are not considered worthwhile. For this reason, the same meanings of euthanasia, of illness/health, in changing their interpretive paradigm, appear to man in forms that are incisive in effect and in forms that are increasingly less scandalous than was the case in the past.

What Kind of Meaning for Euthanasia?

The original etymological meaning of 'euthanasia', from the ancient Greek *eu-thànatos*, good death, has had different contents and meanings over recent years.

Today, thanks to the innovations of medical technology, it is possible both to artificially prolong the life of a terminally-ill patient (disproportionately intense treatment) and to procure death before its due time (euthanasia).

Euthanasia, in fact, involves deliberately bringing about death in a direct or indirect way, that is to say ending the life of a person through an action which involves commission or omission

– out of compassion;

– in order to reduce suffering;

– in order to comply to the wishes of the sick person.

Western culture emphasises the right to self-determination on the part of the patient, as well as the right of the health care worker, and especially the medical doctor, to respect the principle of benefit, and thus goes so far as to uphold the right to euthanasia.

The wish to put an end to a life or to meet the request to end a life which is seen as not being worthy of being lived in the eyes of contemporary utilitarianism, cannot be accepted either as a right or as psychological pietism.

A right is human because it belongs to being, and this, because of the ontological paradigm of being-for another, constitutes the co-existentiality that alone can render a choice legitimate. Whereas in the sphere of a relationship based upon a contract between the doctor and the sick person the principle of self-determination can justify the request for euthanasia, in the sphere of the therapeutic alliance the constitutive sharing of the experiences of being cannot aspire to provide responses to such a request. This is true both for procured euthanasia and for assisted suicide, and even more for those conditions in which the health care workers believe that the life of their patient is not worthy of being lived according to the utilitarian paradigm – the intrinsic *thelos* of nature and co-existentiality require being, side by side with psycho-assistance and pain-reducing forms of care. Post-modern secularism, which seeks to evaluate life from the point of view of efficiency and in terms of the dignity of the being that is experienced, that is to say stewarded in a responsible way, has influenced the very concept of health care. This care must be

THE VOCABULARY OF THE GOOD DEATH

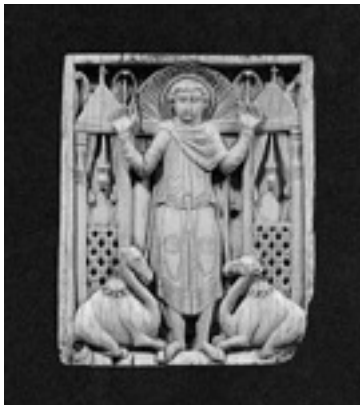
Active, direct or positive euthanasia	The health care worker intervenes directly to procure the death of a patient
Passive or negative or indirect euthanasia	This involves refraining from measures which could keep a patient alive
Voluntary euthanasia	The euthanasia repeatedly asked for by the patient
Non-voluntary euthanasia	The patient is unable to make a request for euthanasia because he or she has been rendered incapable
Involuntary euthanasia	A health care measure designed to suppress life despite the express dissent of the patient
Dystanasia	Refraining from health care measures to prolong life which do not respect the dignity of the patient
Physician assisted suicide	The suppression of the life of a patient as a direct consequence of a suicidal act by the patient, but advised and/or assisted by a health care worker

directed towards defending the quality of the different categories by which life is expressed more than towards defending life itself as a fundamental value. The quality of life means a life interpreted according to the parameter of well-being consciously chosen by the subject himself or herself. A conscious choice requires the health care staff to respect the wish of the sick person, and in this they should avoid all forms of paternalism.

Every form of treatment must be accompanied by the informed consent of the patient but his or her wishes cannot eliminate the rights of the medical doctor who must always engage in therapeutic action and not mere technological applications directed towards the mere extension of the biological functions or their premature ending. The informed consent of the patient and the healing objectives of medical action must also guide health care workers in the case of a patient who has lost his or her mental faculties (because of age or illness). The loss of mental faculties must not be adopted as a criterion for procuring the death of the patient – the ethical and deontological principle of doing good to a sick person as a sharing of experiences must involve a rejection of every initiative in favour of the practice of euthanasia.

Lecaldano[48] stresses that 'each person is completely responsible for his or her life, and only that person can be directly responsible for it, for his or her own life. For each human being the following principle is valid: my life is totally mine and I am the only person who is directly responsible for it'.

This freedom connected with the autonomy of being able to take one's own life is totally baseless because freedom is the realisation of an existential state and not its suppression. By death we do not express our own freedom, indeed we deny it, in the sense that death ends every right. The meaning of autarky and of autonomy are often confused. Autarky involves being responsible for oneself in a total way, and thus an individual never has to answer for what he does – this amounts to authentic social suicide in that it closes that social-relational dimension that began on the day of his or her conception; whereas to accept the relational dimension means to limit oneself but at the same time to achieve real autonomy – freedom. For that matter the condition of freedom would not exist if not to the extent to which a subject interacts with other people. This is freedom which is constructed and fulfilling.[49] In addition, our life is not something to be disposed of; it is entrusted to us so that it is fulfilled in the corporeal experience of each and every man. The human sciences (anthropology, sociology) have always seen man as a good not only in himself but in a relational perspective.



Social power, political-economic prestige, are the qualities of cohesion and co-operation between the members of a group. Catholic theology itself has always proclaimed this two-dimensional opening: man, man-God. With the advent of extreme subjectivism man has transformed the experiential horizon into what is merely an existential solipsism. Human existence, that is to say being-in-the-world involves a going beyond oneself in order to open oneself to another person-in-himself. This premise justifies the approach of rejection of every form of self-damage, in the extreme intentional cases of ending one's own life, as takes place in the case of suicide. The pre-modern cultural tradition always proclaimed that life cannot be disposed of at will and thus also condemned its planned termination. This was in line with the non-solipsistic character of human existence. Human existing, that is to say its openness to the person-amongst-us, involves responsibility, if not of a religious kind, then certainly of a socio-juridical character. Indeed, there is an imperative that man should commit himself to maintaining and respecting this relational net for the being-well of mankind, that is to say he should defend life as a sharing of experiences.

The Civil Code of Italy itself in article 5 envisages and prohibits any medical activity that can bring about a permanent disability, that is to say that can alter human life in terms of its integrity and dignity. The same principle of doing good cannot be interpreted as doing to others what they ask us to do – in the case in hand procuring death or helping somebody to die. The principle of doing good intrinsically obliges the health care worker to do good to his or her patient, in the sense of procuring him or her benefits in defence of his or her life and his or her dignity whatever his or her existential state might be. The Italian Constitution itself is pro-life when it upholds as a fundamental right the defence and the dignity of human life. Indeed, article 2 'recognises and guarantees the inviolable rights of man both as an individual and in the social formations in which he develops his personality...'; in article 3 'all citizens have equal social dignity and are equal before the law, without distinction of sex, race, language, religion, political opinions, and personal and social conditions. The Republic has the task of removing those obstacles... that... hinder the full growth and development of the human person...'; in article 27 we read that 'penal responsibility is personal... punishments cannot involve forms of treatment that are contrary to the meaning of humanity... the death penalty is not allowed...'; and article 32 proclaims: 'the Republic defends health as a fundamental right of the individual... Nobody can be forced to undergo a certain form of health care treatment unless by a special legal provision. The law in no case can violate the limits imposed by respect for the human person'.

The professional codes of conduct of health care workers, continuing the well-known ethical imperative of Hippocrates

EUTHANASIA IN THE WORLD

CALIFORNIA (1976)	The decriminalisation of euthanasia; recognition by the Natural Death Act and Living Wills (biological testaments).
THE SWISS CANTON OF ZURICH	Passing of a law on euthanasia
STATE OF WASHINGTON	After the Cruzan case, the Patient Self Determination Act was passed, which, however, was rejected by a referendum in 1991.
HOLLAND (1993	The decriminalisation of euthanasia. In 2001 euthanasia practiced by a medical doctor after being requested to do so was legalised, thereby freeing the health care worker from criminal responsibility. The request of the patient must be voluntary, well thought through, lucid, repeated, and long-lasting; his or her suffering must be unbearable and lacking in any prospects of improvement. The personal medical doctor of the patient must examine the question with a colleague, and then report the action to a special committee of experts which will then assess whether the procedures envisaged by the law have been followed.
NORTHERN TERRITORIES, AUSTRALIA	The legalisation of euthanasia, where it was seen as a right *sub conditione*; this law, however was abrogated by a Federal law of 1997.
THE SUPREME COURT, USA, 1997	A sentence of this court excluded the inclusion within the Constitution of the right to choose the form and the time of one s own death. It was up to each individual State to legislate on euthanasia and assisted suicide. Oregon authorised assisted suicide in the same year: lethal drugs are prescribed by the medical doctor but not administered by him or her.
JAPAN	Euthanasia is allowed in the presence of four circumstances: when the patient is suffering from physically unbearable pain; when death is inevitable and imminent; when all measures possible have been taken to reduce pain; and when the patient has expressly given his or her consent.
ITALY	There is no law which decriminalises or legalises euthanasia. In 1984 Fontana MP introduced a Bill on the dignity of life and the regulation of passive euthanasia , which so far has not been acted upon. The only elements which regulate the question are to be found in articles 579 and 580 of the Penal Code and the professional code of practice.
FRANCE	On 3 March 2000 the French National Ethical Committee, for the first time, referred to the exception of euthanasia , that is to say a possible decriminalisation of this act in certain cases. For the Committee, the idea of an exception in the case of euthanasia was able to sanction the sound beliefs of people, taking away the veil of hypocrisy and the hidden that conceals certain contemporary practices . The existing religious confessions, with the exception of the Protestants, have expressed opinions contrary to this position. The French Catholic Church does not adhere to the idea of an exception in the case of euthanasia, a legally recognised exception would rapidly lead to the progressive loss of a principle which is still in legal terms held to be fundamental . Despite the fact that euthanasia is illegal, the Penal Code makes a distinction between active euthanasia (the direct procuring of death is murder) and passive euthanasia (the absence of therapeutic action).
GERMANY	In 1998 the Court of Appeal of Frankfurt established that in principle euthanasia can be authorised only if it conforms to the wishes of the patient. It must, however, be approved by a committee of tutors.
GREAT BRITAIN	Euthanasia is illegal but in certain cases the judicial system has authorised the shortening of the lives of patients kept alive by artificial means. For the first time, in 1996, the death of a patient was authorised .
DENMARK	An incurably ill person can halt his or her medical treatment. Since 1992 Danes can make a medical testament which medical doctors have to respect.
SWITZERLAND	Assisting a suicide is a transgression of the law which is not punished. In extreme cases the medical doctor can turn off the machines sustaining the breathing of the patient.
CHINA	In 1998 the government authorised hospitals to practice euthanasia on patients in a terminal stage of an incurable illness.[50]

– 'I will not provide any lethal drug even if asked to do so' – obliges those adhering to these codes to refrain from any form of euthanasia. The 1998 professional code of conduct for medical doctors, whereas it restates in article 14 that 'the medical doctor must refrain from persisting in forms of treatment

which cannot be expected to produce benefits for the health of the patient and/or an improvement in his or her quality of life', goes on in article 36 to emphasise that 'the medical doctor, even if requested to do so by the patient, must neither carry out nor favour forms of treatment intended to bring about his or her death'. The 1999 professional code of conduct for nurses is very categorical when it affirms in article 417 that 'the nurse shall not take part in forms of treatment intended to bring about the death of the person who is being cared for, whether the request comes from the person concerned, his or her family relatives, or others'.

Moral Aspects of Euthanasia

The 'Manifesto on Euthanasia' (*The Humanist*, July 1974) was signed by important scientists and winners of the Nobel prize, including Jack Monod. This last figure, convinced that the universe and man himself emerged by chance and by necessity, argues that man is the arbiter of himself, and is alone in this world without any ethical or normative reference point. For this reason, man 'has the right to die with dignity... he is free to rationally decide about his own destiny... the means must be created for a sweet and easy death... when life has lost all dignity, meaning, and prospects for the future'. Melina[51] defines this statement as being 'the rhetoric of death', which can be arranged into rhetoric on death, the subject of a formal and empty analysis, or a typical persuasive argument, specific to Platonic rhetoric, so that death can be presented in such a way that we are convinced that we should accept it, not by involving us intellectually or philosophically but by working on the emotions of the moment. This is an attempt to tame death, but first and foremost it should be made clear that death is a fact and not a right: man has the right to steward and defend the life that has been given to him; death does not belong to man and cannot be in man, but is something which prevails when you are least thinking about it.

The old Latin motto of the litany '*A subitanea et improvvisa morte, libera nos, Domine*', on the other hand, makes clear to us the meaning of dying with dignity, and as a result the value and the meaning of 'the right to a good death', that is to say a death where one is serene with oneself, with other people, and if one is a believer, with God, alleviated of one's pain and suffering.

In this approach are to be found all the documents of the Church's Magisterium: *Iura e bona* (1980), the recent encyclical *Evangelium vitae* (1995), and the *Charter for Health Care Workers* (1995). This last reaffirms that a health care worker has the task of 'always being at the service of life and assisting it to the end' (n. 148) and that in practicing or allowing euthanasia 'he is no longer the absolute guarantor of life: the sick person will be afraid that the doctor will cause his death'. For scientific research and medicine in particular, euthanasia is 'a backward step of surrender, as well as an insult to the personal dignity of the one who is dying' (n. 150).

Contemporary man sees pain and suffering as a mysterious and difficult reality which has to be accepted and lived out. Faced with physical, mental or moral suffering, man tends to adopt desperate approaches:

a) of rejection (taking refuge in pleasure, in escape, and forms of evasion);

b) of fatalistic endurance (abandoning forms of treatment and care);

c) of fighting against suffering by using every medical technical possibility that is available;

d) of giving value to things, as an instrument of personal growth, by which to understand the meaning of life, and aware acceptance of a personal biographical event.

The different ways of approaching suffering, the process of dying, and the event of death, depend upon the following points of reference:

– Those of an anthropological character. The meaning attributed to the human person, the concept and the definition of life and illness (illness as a punishment, death as a misfortune and malediction), and the cultural inheritance of the subject involved (death as a heroic action, or death as the failure of man).

– Those of a psychological character. (The cognitive-psychological approach): the tragic character of separation from a loved one generates feelings of fear of the unknown, the emergence of reactive mechanisms of denial and projection (my relative is not in such a bad condition as that person there and that person there is older, or my relative has not been given a certain treatment). Death as a mysterious and painful event is experienced as something that disturbs, with the generation of an incapacity for realistic acceptance and thus its working out (mourning).

– Those of a theological character. Catholic theology, in particular, sees death as a passage-birth towards a better life and a moment when the divine comes to be encountered.

As a result, the patient who suffers or is in the final stage of his or her illness should be provided with moments of support, of welcoming, as regards suffering and death, because health, illness, and death are constituent elements of human finiteness, that is to say they are parts of our lives. They have to be known about and under-

stood, accepted and welcomed, indeed they should be made more human through a caring and helpful human presence on the part of both the family relatives and the health care workers who should try through their forms of therapeutic helping service (pain reducing treatment) to reduce that patient's suffering (the presence of the family relatives and the health care workers becomes listening and therapy), something that is essential to make death as painless and as natural as possible.

Thus a less isolated event and an event that involves the co-presence and the co-participation of the family relatives, a pastor of souls if the patient is a believer, and health professionals (medical doctors and nurses), in a welcoming environment in the patient's own home or suitable structures (e.g., a hospital or a hospice).

Suffering and the Request for Euthanasia

Illness involves suffering and is a challenge for the person, changing his or her existential experience: affection, work, social relations, all of which express inner trial. The first change, when the illness appears, regards the status of the patient – from a healthy person he or she becomes pushed towards adaptation to a new condition that leads him or her to face up to internal problems of a psychological and spiritual kind as well as external problems relating to behaviour.

With the arrival of the illness the subject turns himself or herself inwards onto his or her own body, he or she must listen to it, control it, and understand the messages that it sends to him or her.

In the face of suffering the person structures (or destructures) himself or herself in a series of chrono-biological reactive stages, based upon mechanisms of self-defence which characterise each such stage.

For Kubler-Ross, the drawing near of the final *exitus* is characterised by an evolutionary series of emotional reactions, which do not always follow one another and which need not necessarily take place. They are as follows:

– a first moment characterised by flight into denial or isolation. For example, the sick person goes from one medical doctor to another in the vain search for somebody who can provide him or her with a more favourable diagnosis;

– a second moment characterised by rage which is expressed to everyone, and by the question: 'why has this happened of all people to me?';

– a third moment characterised by 'coming to terms', that is to say by a negotiation with destiny or with God;

– a fourth moment characterised by depression, where rage is replaced by a feeling of loss and of separation;

– lastly, if the sick person has the good fortune to find somebody who helps him or her, it is possible for him or her to achieve the acceptance of death.

Thus for Kubler-Ross, acute worry about death cannot be overcome, but man is able to give meaning to this experience.[52] On this point it is interesting to note the study described by Tambone and carried out by the Campus Biomedical University on the relationship between illness and death and the request for euthanasia.[53] All the requests for euthanasia turned out to be rooted in the state of health of the patient, no patient asked for euthanasia out of a mere wish to die – euthanasia was seen as a solution to the patient's suffering. In particular, a request for euthanasia was connected to three factors: physical pain, a state of depression, and fear of being a burden on the patient's family, all of which contributed to bringing about total pain, These factors mean that health care workers and experts in health care policies should adopt three kinds of approaches, which may be described as follows:

a) having the wish to uphold the right to euthanasia should not be seen as such. Indeed, the motivations behind the requests for euthanasia are to be located in the desire of patients to be listened to; they are cries for help. A wish cannot be converted into a right leading to a public legitimation of the actions and instruments adopted to uphold that right. Such a tendency is encouraged by the permissive approach of political power, which manipulates the mass media in a search for public support and is ready to sanction certain personal needs underpinned by the social emotionalism specific to certain social situations such as suffering, fear of the unknown and of the mystery which accompanies death, rather than becoming a promoter of norms to defend such values as those of life. Instead, the right to die in a dignified way is legitimate, where this is understood as a natural human process that leads to the end of human existence. The wish to die cannot be seen as a right – we have a right in relation to things or ideas, or we have the right to profess a faith, but we do not have a right in relation to an event to do with an entity which cannot be disposed of, namely our life.

b) The acceptance of euthanasia would constitute a capitulation as regards the purposes of medicine, which, if it cannot actually heal should at least seek to take care of a sick person. Death neither prevents not treats illness but eliminates the person, and this represents the de-ranking of the asserted omnipotence of medicine. Spagnolo is right when he writes: 'the essence of the medical profession is to treat, to give life, not to distribute death... death... may never be defined as a medical action'.[54]

c) A request for euthanasia, on the other hand, is a challenge to the whole of humanity to respond to the call for help in the context of unbearable pain, isolation, the indifference of other people, to unawareness about the limits to treatment and care which can degenerate into forms of euthanasia and

therapeutic overkill. We have to know how to address not only physical and mental needs, through suitable pain-killing treatment, but also the spiritual needs of the patient, fostering any kind of opening up to the transcendent on the part of the sick person.[55]

Persistent Vegetative States

The persistent vegetative state (PVS)[56] is what primarily raises the question of euthanasia and therapeutic overkill. This condition arises after a very serious traumatic injury or a vascular accident within the brain. After a stage of coma of varying levels of length, the patient enters into a clinical state characterised by a complete absence of the functions of the cerebral hemispheres (the cortex responsible for the function of psychological consciousness), although the encephalic trunk (which controls the respiratory, cardiac, and thermoregulatory functions) remains intact. This situation can be *transitory* (up to thirty days) and involve a return to a state of consciousness. When thirty days have passed a persistent vegetative state is referred to. Such a state can be the anti-chamber to a late regaining of consciousness, with a return, usually incomplete, of functions, or, differently, a definitive sliding of the patient into a *persistent vegetative state*, which is practically irreversible when the PVS lasts more than eight months after a traumatic injury or more than three months after a non-traumatic injury. A patient in a persistent vegetative state breathes, swallows, reacts to light and pain, and has a sleep/being awake rhythm, even though he or she is in a state of complete unconsciousness. Thus we are dealing here with an individual who is alive and not yet dead. In this clinical situation, whereas there is agreement that special forms of treatment should not be engaged in, there remains disagreements about the forms of care which should be provided in this state in order to ensure survival and a certain level of decorum and respect for the patient. Faggioni[57] argues that an absolute irreversibility between simple persistence and permanence is not presently possible and that therefore measures of help in terms of forms of care and treatment should never be interrupted. On this point, the Pontifical Academy of Sciences[58,59] made a distinction between treatment and care in the following terms:

– by *treatment* is understood any medical action (chemotherapy, radiotherapy) or surgical measures, of various level of technical complexity and economic and human costs, which are available and appropriate for the treatment of a given clinical case, directed towards the healing, the improvement or the stabilisation of the psycho-physical conditions of a patient: in the case of persistent coma there is agreement that special forms of treatment should not be engaged in;

– by care is meant every form of medical, psychological and helping action directed towards maintaining the psycho-physical conditions of the patient in the best possible state until death. Amongst forms of care we list hydration, alimentation, the sedation of pain and the prevention of the formation of sores, all of which should be implemented.[60] The Magisterium of the Church expressed itself along these lines in 1981 when it defined the minimum obligatory measures that have to be employed,[61] namely, for example, hydration, and emphasised the strict obligation to proceed at any cost with the implementation of such measures.

Hippocratic medicine, which is often forgotten by health care workers, argued '*medicus curat, natura sanat*'. Medical action comes up against its limitations precisely when the patient is in a terminal state and has to give way to the intrinsic teleology of the nature of being. From the point of view of the relationship between the medical doctor and the patient based upon the alliance of two actors, neither of the two can predominate over the other, but because of the constitutive and directive principle of human nature, the medical doctor cannot take initiatives to shorten or uselessly lengthen the life of the patient, who by now has come to the end of his or her existence. But by the same principle of human co-existentiality, a patient cannot uphold his or her right to euthanasia or to therapeutic overkill – there prevails, instead, the duty to defend this co-existentiality upon which society is based. Medicine itself takes on its therapeutic character at the moment in which it procures *salus* for the sick person according to the law of nature. In relation to an incurable illness, medicine offers its skills and expertise, and its limitations may not be defined as defeats but as a recognition of its constituent limits. From this point of view are to be seen proportional forms of assistance and pain-killing treatment. These health care services, although they do not lead to healing, reduce suffering and at a symbolic level realise that being with others through being next to someone, thereby overcoming the solipsistic climate frequently to be found in the terminally-ill pa-

tient and bringing about the constituent co-existentiality of being. In this way death becomes co-sharing, that is to say a relational human experience.

The above quoted 'Declaration on Euthanasia, Iura et Bona' of 1980,[62] argued that 'near to an inevitable death, despite the means employed, it is licit at the level of conscience to take the decision to abandon forms of treatment that would procure only a precarious and painful prolonging of life, without, however, interrupting the normal forms of care due to the patient in such cases. For this reason the medical doctor should not worry too much, as though it were the case that he or she had not provided assistance to a person in danger'. The 'Charter for Health Care Workers' of the Pontifical Council for Pastoral Assistance to Health Care Workers, in article 120, emphasises that 'the administration of foods and liquids, even artificially, is part of the normal treatment always due to the patient when this is not burdensome for him: their undue suspension could be real and properly so-called euthanasia'.

The supporters of quality of life[63] as a parameter for good sense and law in the treatment of sick people criticise the defenders of the ethics of the sacredness of life, because these latter are said to see in the rejection of therapeutic overkill the adoption of quality of life as a discriminating element in the therapeutic operation. But the error of their logic of interpretation is to be found in seeing the sacredness of life from a materialistic point of view. In reality, the supporters of the sacredness of life see the life of the human subject as a transcendental value that is expressed in daily life in virtue of the co-constituent existentiality of every man, whereas the biological component of man is an empirical category of life itself. Understood in these terms, the value of life is distinct from a mere biological perception, indeed it rises above it and confers a horizon of meaning upon it, and in relation to the terminally-ill person it authorises the moral conscience of the health care worker to abandon disproportionate forms of care and treatment.

As regards disproportionate forms of care and treatment, this is described at length in section 120 of the 'Charter for Health Care Workers' of the Pontifical Council for Pastoral Assistance to Health Care Workers, which has already been quoted. The Charter reads as follows: 'Aware that he is "neither the lord of life nor the conqueror of death", the health care worker, in evaluating means, "should make appropriate choices, that is, relate to the patient and be guided by his real condition".[64] Here he will apply the principle – already stated – of "appropriate medical treatment", which can be specified this: "When inevitable death is imminent, despite the means used, it is lawful in conscience to decide to refuse treatment that would only secure a precarious and painful prolongation of life, but without interrupting the normal treatment due to the patient in similar case. Hence the doctor need have no concern; it is not as if he had failed to assist the person in danger".[65] The administration of food and liquids, even artificially, is part of the normal treatment always due to the patient when this is not burdensome for him: their undue suspension could be real and properly so-called euthanasia'.

Dr. FRANCO DAVIDE PILOTTO,
Medical Director
Az. USL Region 15 Veneto,
Graduate in Philosophy
and Diploma in Theology,
Contract Professor in Bioethics,
the Faculty of Medicine and Surgery,
the University of Padua and Verona.

Notes

[1] E. FROMM, *Anatomia della destruttività umana* (Italian edition, Milan, 1975).

[2] P. ARIÈS, *Storia della morte in occidente* (BUR, Milan, 1998).

[3] J. MCMANNERS, *Morte e illuminismo. Il senso della morte nella Francia del XVIII secolo* (Il Mulino, Bologna, 1984).

[4] M. VOVELLE, *La morte e l'occidente. Dal 1300 ai giorni nostri* (Laterza, Bari, 1986).

[5] N. ELIAS, *La solitudine del morente* (Il Mulino intersezioni, Bologna, 1999).

[6] *Ibid.*, p. 82.

[7] R.A. MOODY, *La vita oltre la vita. Studi e rivelazioni sul fenomeno della sopravivenza* (Mondadori, Milan, 1977).

[8] S. KIERKEGAARD, *Accanto ad una tomba* (Il Melangolo, Genoa, 1999).

[9] *Ibid.*, p. 41.

[10] *Ibid.*, pp. 38-40.

[11] *Ibid.*, p. 53.

[12] *Ibid.*, p. 52.

[13] *Ibid.*, pp. 70-1.

[14] *Ibid.*, p. 76.

[15] S. KIERKEGAARD, *In concetto di angoscia* (Florence, 1966), p. 9.

[16] M. HEIDEGGER, *Essere e tempo* (Longanesi & C., Milan, 1976), p. 22.

[17] In the philosopy of Heidegger the idea of existence defines the singular existence of man who exists being outside in being. The existentives explore this essence (that is to say the ways in which man decides regarding the alternative possibilities of existence) and the existentials (the structures that define existence itself, such as the affective situation, understanding, anxiety), hence the distinction relating to the ontical – the concrete, the contentistic, and the existentive: structural, formal, and existential. For this reason, existence can be understood as factness or factual dataness, as exterior ontic phenomenality: the entity is of itself being and exists because it appears; it expresses itself in a determined way according to its determinedness and concreteness.

[18] M. HEIDEGGER, *Essere e tempo* (Longanesi & C., Milan, 1976), pp. 45-53.

[19] In his book 'Il concetto di tempo' (Adelphi, Milan, 1998), M. Heidegger stresses that 'in my existing, in fact, I am always 'still on a journey'. It is always something that has not yet reached its end... Before this end it is never properly that which can be; and if it is, then it is so no longer... The end of my being here, my death, is not something because of which at a certain moment a constant process suddenly stops, but a possibility in which the being here nonetheless knows: it is the extreme possibility of oneself, that can be accepted and made one's own as imminent. Being-here has in itself the possibility to encounter its own death as the extreme possibility of itself. This extreme possibility of being has the characteristic of being imminent as certainty, and this certainty in turn is characterised by a complete vagueness... What is to have cognisance of one's own death? It is is precursor of being-here which goes to its no-longer as extreme possibility of being oneself that is imminent in its certainty and complete vagueness. Being-here as human life is primarily a possible-being, it is the being of the possibility of no-longer, certain and yet undetermined... This forerunning is nothing else but the unique and authentic future of one's own being here', pp. 48-9.

[20] G. MARCEL, *Homo viator* (Rome, 1967), p. 170.

[21] L. ALICI, 'Filosofia della morte', in AA.VV, *La dignità degli ultimi giorni* (Cinisello Balsamo, 1998), p. 92.

[22] I. CARRASCO DE PAULA, 'Morte cerebrale: aspetto etico-filosofici', *Medicina e Morale*, 5, 1993, p. 892.

[23] P. CATTORINI, *Sotto scacci, Bioetica di fine vita, Liviana Medicina* (Naples, 1993).

[24] The Harvard Committee also sets out the criteria for the identification of the presence of death: an absence of receptivity and responsiveness; an absence of spontaneous movements; apnea, an absence of reflexes (of the brain and the limbs), and a flat EEG (Ad Hoc Committee of the Harvard Medical School, 'A Definition of Irreversible Como', *JAMA*, 6, 1968, pp. 337-338.

[25] On this point the nosographic entity of hedematose troancoencephaltis is recognised, something which in certain cases can be reversed through medical

treatment. This confirms the soundness of the adoption of the criterion of total cerebral death as a parameter to declare that a human organism has met with death.

[26] F. D'AGOSTINO, 'Morte', in F. COMPAGNONI (ed.), *Etica della vita* (San Paolo, Cinisello Balsamo, Milan, 1996).

[27] I. CARRASCO DE PAULA, *op. cit.*, p. 894.

[28] G. PERICO, 'La nuova legge sull'accertamento di morte', *Aggionamenti Sociali*, 4, 1994, 405-416.

[29] Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* , n. 129.

[30] K.G. GERVAIS, *Redefining Death* (New Haven, Yale University Press, 1987).

[31] D.R. SMITH, 'Legal Issues Leading to the Notion of Neocortical Death', in R.M. ZANER (ed.), *Death: Beyond Whole Brain Criteria* (Dordrecht, Kluwer, 1988), p. 129.

[32] K.G. GERVAIS, *Redefining Death* (New Haven, Yale University Press, 1987), p. 11. 33. M.B. GREEN and D. WIKLER, 'Brain Death and Personal Identity', in M. COHEN, T. NAGEL and T. SCANLON (eds.), *Medicine and Moral Philosophy* (New Jersey, Princeton University Press, 1981).

[34] A.E. WALKER, D.M. FEENY and D.A. HOVDA, 'The Electrocephalographic Characteristics of the Rhombencephalectomized Cat', *Electroencephalography and Clinical Neurophysiology*, 57, 1984, 158-165.

[35] T. KUSHNER, 'Having a Life versus Being Alive', *Journal of Medical Ethics*, 10, 1984, 5-8.

[36] H. JONAS, *Della fede antica all'uomo tecnologico* (Il Mulino, Bologna, 1991), p. 218.

[37] J.M. STANLEY, 'More Fiddling with the Definition of Death', *Journal of Medical Ethics*, 13, 1987, p. 22.

[38] K.G. GERVAIS, *Redefining Death* (New Haven, Yale University Press, 1987), p. 175.

[39] G.R. GILLETT, 'Why Let People Die?', *Journal of Medical Ethics*, 12, 1986, p. 84.

[40] D. LAMB, *I confini della vita. Morte cerebrale ed etica dei trapianti* (Il Mulino, Bologna, 1987).

[41] J. RACHELS, *La fine della vita* (Sonda, Milan, 1989), pp. 11-12.

[42] G.R. GILLETT, 'Why Let People Die?', *Journal of Medical Ethics*, 12, 1986, p. 85.

[43] On the persistent vegetative state and in particular the dramatic case of Nancy Cruzan, which divided American public opinion at the end of the 1980s, see C. Manni, 'Sindrome appallica', in S. Leone and S. Privitera, *Dizionario di Bioetica* (Acireale-Bologna, 1994), pp. 904-907; A. Puca, 'Il caso di Nancy Beth Cruzan', *Medicina e Morale*, 42, 1992, pp. 911-931.

[44] According to Aristotelian doctrine, the soul (or substantial form) is the form of the body, and it is inseparable and inconceivable without its relationship to the body. For that matter, Boethius defines as a person every individual substance of a relational nature, as a result of which relational nature does not only involve what is functionally or empirically ascertainable but what can be argued rationally within a conception of being and its levels of perfection. F. Compagnoni, on this point, retrieves the ileomorphic theory and proposes a phenomenological reading: 'Considered in its manifestation, the body of man cannot be defined in opposition to the soul. What man experiences in the living human body is the operative unity of its components which do not subsist and cannot even exist in a state of distinction. In the organic body we find ourselves faced not with chemical components or partial organisations but with a living organism which does not subsist except during the integrated union of the various elements and partial organisations. This allows us to speak about an internal teleology of the human body in the sense that every simple or organised part is organised with the end in view of survival or well-being, to the constancy in time of this body. The organising principle (*morphé, entelécheia*, of Aristotle) is that called the soul in man, and which in this sense has a prevalence in terms of ends in relation to the body, but this is certainly not spatial or temporal. The human body (Leib) is the result of the action of the soul in relation to this matter; this maintains many aspects of materiality, of corporeity (Korper), but what this has at the level of living, of human living, is the effects of two sets of co-causes, which, separated, are thinkable and thus can be described and defined only with great difficulty... The very fact that a human organism renews itself constantly through metabolism and its chemical/physical components and renews most of its own cells without this meaning that one is dealing with a new body, is a sign that it is the *psyché* that produces and maintains its own body. This last is the same... in that it is united to and organised by the same soul, which is human and personally individual... The soul can thus become a term to indicate that aspect of the human-living-substance to which to attribute the causality of the activity of the subject: abstract knowledge and volition of objects that are not immediate can be attributed to it. The physical body, instead, can be a term to be attributed to extension, and thus to the possibility of being seen, first through the sense, but subsequently known also in an intellectual way', see F. Compagnoni (ed.), *Etica della vita* (San Paolo, Cinisello Balsamo, Milan, 1996), pp. 33-56. Thus death should be understood in its totality as an integrated system, as indeed it is seen in different sets of legislations: the death of the body-nervous system.

[45] M. HEIDEGGER, 'La Cosa', in *Saggi e discorsi* (Mursia, Milan, 1976), p. 119.

[46] R.L. LUCAS, *Antropologia e problemi etici* (San Paolo, Cinisello Balsamo, Milan, 2001), pp. 147-8.

[47] The metholodological approach of the observations that follow often derive from the accurate analysis carried out by F. D'AGOSTINO, *Bioetica* (Giappichelli Editore, Turin, 1996), to which the reader is directed for a deeper consideration of the question.

[48] E. LECALDANO, 'Questioni etiche sui confini della vita', in A. Di Meo and C. Mancina (eds.), *Bioetica* (Laterza, Rome-Bari, 1986).

[49] A. THÉVENOT, *La bioetica* (Queriniana, Brescia, 1990).

[50] Data taken from *L'Ancora* June 2001.

[51] L. MELINA, *Bioetica* (Piemme, Casale Monferrato, 1998).

[52] F. PILOTTO, 'Come affrontare la sofferenza umana: problemi psicologici', *Impegno Ospedaliero*, XXII, July 2001, 3-8.

[53] V. TAMBONE, *Problemi di bioetica e deontologia medica* (Società Editrice Universo, Rome, 2000).

[54] A. SPAGNOLO, 'Perché non condivido l'eutanasia', *Le Scienze*, 88, 1996, pp. 52-3.

[55] M. PORTIGLIATTI BARBOS, 'Eutanasia', *Professione*, 88, 1996, 40-44.

[56] C. DEFANTI, 'Stato vegetativo persistente e morte clinicale', *Le Scienze*, 88, 1996, 40-44. 57. M. FAGGIONI, 'Stato vegetativo persistente e morte corticale', *Studia Moralia*, XXXVI/2, 1998, 523-552.

[58] Pontificia Academia Scientiarum, C. Chagas (ed.), *Working Group on the Artificial Prolongation of Life: the Determination of the Exact Moment of Death* (Vatican City, 1985), translated into Italian by M. Morgante: *L'eutanasia è un crimine* (Editrice elle de ci, Leumann, Turin, 1986), pp. 46-7.

[59] In 1950 Pius XII, in the area of the provision of health care services to the terminally ill, in referring only to means, made a distinction between: ordinary (obligatory) means – hydration, alimentation, and hygienic care; and extraordinary (facultative) means – surgical operations, chemotherapy and radiotherapy, which help to increase pain, risks and excessive costs. Today we prefer to make a distinction between proportionate means and disproportionate means, taking into consideration not only the means but also the clinical state of the patient and the real benefits that can really accrue to the patient. In the case of patients in a persistent vegetative state, hydration, alimentation and personal hygiene are proportionate ordinary forms of care intended to avoid an early death, leaving the basic illness to follow its natural course.

[60] S. LEONE, *Il malato terminale* (San Paolo, 1996).

[61] Pontificio Consiglio "Cor Unum", *Alcune questioni etiche relative ai malati gravi e ai morenti*, 27 maggio 1981 (Edizioni Dehoniane, Bologna, 1982), p. 19.

[62] Congregazione per la Dottrina della Fede, *Dichiarazione sull'eutanasia, 5 maggio 1980*, chap. 4 (Edizioni Dehoniane, Bologna, 1982), p. 11.

[63] M. MORI, 'Il filosofo e l'etica della vita', in A. DI MEO and C. MANCINA (eds.), *Bioetica* (Laterza, Bari, 1989), p. 95.

[64] Cf. GIOVANNI PAOLO II, 'A due gruppi di lavoro promossi dalla Pontificia Accademia delle Scienze, 21 ott. 1985', in *Insegnamenti*, VIII/2, 1985, n. 5.

[65] Congregazione per la Dottrina della Fede, 'Dichiarazione sull'eutanasia, 5 maggio 1980', in *AAS*, 72, 1980, 551. Cf. *Evangelium Vitae*, 65.

Testimony

Problems of Health in Burkina Faso

The Blessed Luigi Tezza: Founder of the Daughters of San Camillo

Nicaragua: Pastoral Care in Health

Spain: The Department for Pastoral Care in Health

Problems of Health in Burkina Faso

I have known Burkina Faso since 1974. I was there until 1980 in my capacity as provincial superior of the Camillian religious and subsequently I lived there as a resident from 1981 to December 1996. I lived there as a priest but I directed my attention to the problems and the needs of the country and the populations that live in it.

In my discussion of this subject I will confine myself to speaking about four aspects of health and health care in Burkina Faso. First of all, I will provide different kinds of information in order to define the health care context of Burkina Faso. Secondly, I will describe the influences of the local area and of environmental deterioration on the illnesses to be found in the country. Lastly, I will speak about the prevention and treatment of illness and the economic difficulties which have to be overcome in order to implement an overall and systematic plan to combat illness.

1. Some Information in Order to Define the Health Care Context of Burkina Faso

At the beginning of the 1990s the World Health Organisation (WHO) laid stress upon the following worrying features of the health care situation present at that time in the world: the return of malaria and more generally the re-emergence of various tropical diseases which it was thought had been eliminated; the endemic blindness of adults and children in many rural areas of developing countries; the absence of a worldwide pharmaceutical policy and a demographic situation lacking in a responsible approach marked by the two contradictory aspects of the ageing of the North of the planet and the spontaneous growth of the South.

It is a common view that these aspects are still a matter for worry. They concern the whole world but I do not think I am mistaken when I state that they apply to the continent of Africa in a special way. The Fourth Conference of the Ministers of Health of the Organisation for African Unity (OAU), which took place in Swaziland at the beginning of 1991, described in a vigorous way 'African hypermortality'. In all developing countries, the conference observed, infectious and parasite-borne illnesses were at the root of most of premature deaths – it was the shared opinion of the members of the conference that in Africa the quota of such deaths accounts without doubt for a half of the total of all deaths.

In addition to infectious and parasite-borne illnesses and the return of malaria, emphasis should also be laid on the return of cholera, which in addition to being present in Latin America also affects certain countries in Africa. Attention should also be drawn to dracunculiasis or guinea worm infection which afflicts about twenty countries in Africa.

To this picture other diseases should be added which have the reputation of being modern or imported from the North of the planet. I am referring here to tuberculosis, polio, meningitis, tetanus, pertussis, diptheria, and measles. Some of these maladies are no longer a serious problem in European countries but in the continent of Africa they are still fatal in their impact (for example, meningitis and measles). It is often said that Africans do not suffer from heart disease because they are not subject to the stress produced by European lifestyles. However, this is a mistaken belief. Unfortunately, heart disease is present in Africa and also has a future. In addition, to cases of cardiopathic illness due above all else to underdevelopment, such as those involving the heart valves and muscles, there are also to be found illnesses attributed to development, such as angina pectoris and heart attacks. Reference should also be made to arterial hypertension which afflicts from 10% to 15% of all the African populations.

I cannot but speak also of the presence of the disease of the century – AIDS. According to the statistics distributed by the Ninth International Conference on AIDS which took place in Kampala (Uganda), this affliction is in a phase of growth in the Sub-Saharan countries.

Today in the Sub-Saharan countries there are eleven million people infected with the AIDS virus out of an overall population of 560 million inhabitants, and of these eleven million, seven million have full-blown AIDS. This figure constitutes 60% of all cases in the world. In 1984 two million cases were registered, nearly all of which had been transmitted by heterosexual pathways. The most afflicted people are the young generation. The great difference in the incidence of this scourge between rural and urban areas is tending to diminish because of the increasing movement of people. The increase in the incidence of this malady has meant an overburdening of hospital admissions. Indeed, in some cities AIDS victims occupy one half of the hospital beds that are available.

Three groups of countries can be identified in which the HIV infection is especially strong. They are responsible for 90% of the cases of people in Africa who are seropositive. The first group is that made up of the countries of central and eastern Africa (Uganda, Ethiopia, Rwanda and Zaire). These are countries where the infection has been known about since the 1970s and where 30% of the cases are to be found. The second group is that made up of countries located in the west of the continent (the Ivory Coast, Burkina Faso, Ghana and Togo). In these countries about 15% of seropositive Africans are to be found. The countries of southern Africa (Botswana, Malawi, South Africa, Tanzania, Zambia and Zimbabwe) have about 40% of

those who are seropositive in Africa.

An important point of reference by which to establish the state of health of a people is the 'life expectancy' index, that is to say the average life-span which is to be encountered within a people. The following

data are of relevance in relation to this point: in 1994, in the industrialised countries, life expectancy was 77 years; in Latin America it was 68; in the Oriental countries and the Pacific it was 66; in North Africa and the Middle East it was 64; in Sub-Saharan Africa it was 51; but in Burkina Faso it was 47. The differences in infant mortality are even more marked: whereas in the industrialised countries there were seven such deaths for every thousand children born alive, the figure was 38 in Latin America, 84 in South Asia, and 107 in Africa and the South of the Sahara. As regards infant mortality rates in Burkina Faso, the situation was better than in other Sub-Saharan countries – 89 deaths for every thousand live births. This improved situation is also the case when children under the age of five are taken into account. Whereas in Sub-Saharan countries the incidence of such mortality taken overall is 177 to every thousand, in Burkina Faso the figure is 169 for every thousand.

The experts on the causes of illness and the condition of health of the various peoples of the world have carried out research and comparisons on the basis of about thirty factors which traditionally have been indexes of health. As regards my paper, that is to say in order to understand the health care context of Burkina Faso, I think that what I have already outlined above is sufficient for this purpose. I can now go on to address the second of the questions listed above, that of the relationship between the local area, environmental deterioration, and illness.

2. The Local Area, Environmental Deterioration and Illness

Under this second heading I intend to bring out certain causal relationships between the local area and illness. According to information provided by the World Health Organisation, 80% of world illness is caused by a lack of suitable water and by poor environmental conditions which conduce to ill-health. I will now provide relevant information about the local area, water, and illness, and about environmental deterioration and health.

a) The local area, water, and illness

In the equatorial and tropical zone the warm and damp climate favours the breeding of certain species of insects and the outbreak of diseases of which they are the carriers – typanosomiasis, malaria, and yellow fever. In the same zone the production of food, although regular, is for the most part made up of starches. There is a consequent shortage of protein, and this makes the inhabitants susceptible to endemic diseases.

In the tropical zone, with its alternating seasons, the spread of insect-borne diseases is caused by the poor quality of the water. During the dry season the water holes become rare and the water becomes stagnant, becoming thereby centres of disease. During the rainy season the grass grows and favours the movement of the insects which carry diseases. There is then a re-emergence of malaria and other kinds of infections: bilharziasis, river blindness, and cholera nostras.

In the arid or semi-arid zone the same phenomena of the zone of alternating seasons are produced. However in different fashion this zone is characterised by a dry season, which is longer in duration and more severe, and by a shorter period of rains with years of drought. If years of drought follow each other, the low harvest produces malnutrition in terms of protein and calories which in turn impoverishes the human organism and increases vulnerability to the various local diseases, and in particular those which involve cell-based mediation such as measles, gastroenteritis, tuberculosis and leprosy. In this zone, furthermore, the rapid changes in temperature are responsible for numerous afflictions of the respiratory tract and the sand-carrying winds are an aggravating factor as regards conjunctivitis and trachoma. The environmental situation of Burkina Faso shares the characteristics of these last two zones, and this is especially true of the centre and the north of the country.

There are those who maintain that dirty water can contain the germs of over twenty infectious diseases. In discussing this subject I will confine myself to one example, that of diarrhoea illnesses.

Diarrhoea illnesses, such as amoebic or bacillary dysentery, or forms of gastroenteritis, are above all very common illnesses which afflict children in these countries. Every year, because of the lack of clean water, these illnesses cause the death

of about six million children under the age of five. In the arid or semi-arid zones, the heavy concentration of people around rare water holes increases the risks of diarrhoea diseases. Indeed, these water holes are used for all purposes.

It is within this context that it is necessary to locate the health care situation of Burkina Faso. Despite the attempts made at the level of hygiene and the treatment of illness, in Burkina Faso the dominant factor in bringing about premature deaths remains the prevalence of infectious and parasite-borne diseases connected with unhealthy environments and dirty water. I am referring here to diarrhoea illnesses, amoebic dysentery and intestinal parasites. To this should be added the epidemics of measles, meningitis and malaria (16.42% of all deaths are attributed to malaria). To these causes we should today add the deaths brought about by AIDS. Previously in this paper I observed that Burkina Faso belongs to a group of countries where 15% of seropositive Africans live.

After these observations one can say that the fight against the great epidemics or the epidemics which threaten the Sub-Saharan countries begins with knowledge about the relationships between man, the environment and illness. The study of these 'medical ecologies' allows us to understand the differences that occur as regards the prevalence of an endemic disease and to study its prevention and the ways of fighting it, through changes in environmental conditions as well.

b) Environmental deterioration and health

Environmental deterioration is a phenomenon which directly affects Burkina Faso. Indeed, Burkina Faso is a country which belongs to the Sahel and is thus a country threatened by desertification. The principal causes thought to be behind desertification are: the over-exploitation of cultivated land, the free-ranging pasturing of livestock, unplanned deforestation, and the erosion caused by torrential rains or badly organised and effected irrigation.

Of the causes which have just been adumbrated, deforestation merits special attention. It arises from the industrial exploitation of wood for export purposes, from the energy needs of the urban and rural populations, and from clearance measures to produce new cultivable land. But it also involves unpredictable changes in the ecosystem at a local, regional, and planetary level.

With regard to the special effects of deforestation, we may observe that the changes which this phenomenon brings about in the forest ecology in turn alter the behaviour of the carriers of diseases. The new people who come to the cleared land bring with them new diseases. These diseases easily infect the non-immunised local inhabitants and vice versa the local inhabitants transmit their diseases to the newly arrived people. An example of an outbreak of yellow fever caused by deforestation was the epidemic which afflicted Nigeria in 1986-7. Twelve thousand people died and it is estimated that at least fifty thousand people were affected.

In conclusion, I may observe that deterioration in the local area has a direct effect on health when it provokes the appearance of a new pathogenic factor. It has an indirect effect when, in bringing about a reduction of the availability of food, an extension of work time, or the scarcity of essential goods such as drinking water or building materials, there is as a result the debilitation of people who are thereby made more susceptible to all the diseases to which reference has been previously made in this paper.

3. The Prevention and Treatment of Illness

When in 1958 Dr. Carrol Berohorst left the United States of America to go and treat the Indians of Guatemala, he based himself upon the simple principle that 'illnesses are defeated by treating illnesses'. But some fifteen years later he expressed his disappointment and observed that sick people, once they had been treated and got better, returned to their condition of poverty and their illness. It was, therefore, necessary to adopt a wider approach and to realise that health requires people to live in an environmental context which is favourable to their health.

Today, in order to ensure that an environment is favourable to people's health, the following conditions are considered to be of primary importance: education in health care, and in particular such education in relation to women; access to drinking water and the drainage of the local area; and the spread of 'primary forms of health care and treatment'. To these primary conditions should be added food hygiene and a sense of responsibility in demographic matters, or rather in matters relating to population density.

I referred to health care education, and in particular to such education in relation to women, to begin with. The fact is that it is women who reproduce society in a biological and cultural sense. They are mothers and at the same time the educators and nurses of their families. If they receive a good health care education, they improve in a positive way the health care behaviour of all their family. Experience shows that the health care education of mothers is a decisive element in the health of the child – as the health care education of mothers increases, there is an inevitable reduction in the incidence rate of infant mortality, and this to whatever socio-economic condition their family belongs.

A condition of similar primary importance in the defeat of illnesses is the drainage of the local area and access to drink-

ing water. Over a hundred papers on this subject (Esrey, 1991) demonstrate that the drainage of the environment has often reduced the level of infant mortality caused by diarrhoea illnesses by 50%. Sometimes this percentage level, in conjunction with the presence of other positive conditions, has reached a figure of 80%. In the same way, improved water supplies in the countryside has given rise to a reduction in cases of infestation by Guinea worm infection. In Nigeria, for example, 640 thousand cases of this infection were reported in 1989. In 1991, after an improvement in water supplies together with treatment of the malady and efforts at health care education, only 282 thousand cases of this illness were reported.

The concept of 'primary forms of health care and treatment' was defined in Alma-Ata (Russia) during an international conference in which 134 States belonging to the World Health Organisation took part. 'Primary forms of health care and treatment' involve two categories of measures and initiatives: activity concerning economic and social development, such as the promotion of better environmental, food, and hygiene conditions, and the spread of scientifically valid health care services which are socially accessible to all the families of the community. In this context, the declaration of Alma-Ata urged the encouragement of the promotion of the participation of the inhabitants of villages both through the promotion of health care education and through the employment of locally available health care auxiliaries.

On the same occasion generalised campaigns of vaccination were set in motion to combat the most common diseases of the countries of Sub-Saharan Africa.

I will terminate my discussion of this subject with an observation on the problem of demography.

In relation to this question, Africa has strange particularities. Differently from other continents, there is no evident correlation between the lowering of the level of infant mortality (1960: 183; 1994: 89) and the lowering of the birth rate (1960: 49; 1994: 47). Even stranger is the fact that not even female instruction has affected in a significant way the lowering of the birth rate. And that is not all: the present-day growth rate of the African populations is one of the highest in the world and at the same time the levels of population density are some of the lowest.

This means that one cannot address African demography by confining oneself to the question of the birth rate – one has to ask oneself if Africa is sufficiently populated. Indeed, population density affects development. Without a minimum of density, especially in relation to agriculture, no innovating pressure is produced.

4. Health Care Planning and Economic Limitations

The observations made so far in this paper provide us at the same time with a framework and pointers for what should be done to improve the health care situation in Burkina Faso both at the level of care and treatment and as regards prevention. At the level of care and treatment, matters were made clear with precision by the declarations of Alma-Ata and Bamako. These declarations urged the spread of 'primary forms of health care and treatment' and the diffusion of essential medicines and drugs bearing labels indicating their real origins. I would like to add that in Burkina Faso health care reorganisation is underway through a decentralisation which seeks to directly involve citizens in the defence and promotion of their health. This reorganisation envisages the creation of health care regions organised into health care districts. A health care district is made up of a certain number of dispensaries and health care centres which refer to a medical centre, described as being 'improved', and which are provided with multi-clinics, wards, maternity wards, SMI wards, a pharmaceutical room, and a structure for surgery for the most urgent cases. This 'improved' medical centre is usually located in a place which is easy to reach for the outlying dispensaries and health care centres. At the level of prevention, as was observed above, the experts on the subject argue that health care education, access to drinking water, the drainage of the local territory and the environment, and generalised vaccinations are all of primary importance. All this brings out how Africans have a good knowledge of their health care situation and how are aware of the remedies that are needed to improve it.

How, then, can one explain that 'life expectancy' is still roundabout fifty years of age? In other words, how can one explain that the African populations are still weak? We have a proverb which provides an answer: 'health does not have a price but it has a cost'. And unfortunately this cost of health is higher than the economic resources of the country I am here discussing; as is the case, indeed, with all the other countries south of the Sahara. Certain facts bring this out. For example, malaria is still a serious problem for health in Burkina Faso. It is the cause of 40% of the fevers of those who visit the dispensaries. Some examples of research into malaria in this country reveal that the cases of malaria fell by 15% between 1973 and 1981. However, in that latter year it rose again in a relevant way. The same examples of research tell us that a typical case of malaria, taking into account direct and indirect

expenses, costs the output of twelve working days. If one considers that the average monthly wage in Burkina Faso does not reach 200,000 Italian lire, and that the inhabitants

with a wage do not constitute even a fifth of the population, one already has sufficient information to gain an idea of the economic difficulties which every citizen of Burkina Faso encounters in protecting and promoting his or her own health.

I will not examine the cost of other illnesses because assessments and evaluations in this field remain imprecise. However, I would add a general assessment which I made in 1993 and which I believe is still valid in terms of its overall contents when considered in relation to the new context. In the meantime, it may be observed, the inhabitants of Burkina Faso have increased in number and the local currency has undergone a major devaluation.

My assessment referred to the budget for 1991. The national budget of that year in Burkina Faso was 176 milliard, 535 million local francs. At the time the population was about nine million. If we posit a medical prescription for every inhabitant of five thousand local francs, the sum required to pay for medicines alone would amount today to 45 milliard francs. This sum is a fourth of the total expenditure of the country and half the total health budget for 1991. It is clear that we are very distant not only from the sums needed to carry out an overall project of drainage but also from the costs of daily medicines. This situation in Burkina Faso also applies to the other Sub-Saharan countries. Indeed, an analysis of the budgets of the African States brings out the lack of funds which African governments allocate to health. The report of the World Bank of 1985 provided the following structure of the total public expenditure of nineteen African countries:

Health Care Services	5.6%
Collective Services and Social Security	4.7%
Education	16%
Defence	11.4%
Economic and Other Services	62.3%

It is clear that the difficulties which Burkina Faso has to face up to in dealing with its health care situation are very real. It is not only that its financial resources are really short on the

ground. It should also be added that nothing and nobody is encouraging this country to see these problems as really being of primary importance. In searching to achieve its own economic independence, Burkina Faso is forced to direct itself more towards productive activities. Indeed, banks provide funds only in relation to an ability to repay them and with the guarantee that the loans will be used in the ways that the banks themselves indicate.

This is a difficult situation in relation to which the hard work and the creativity of the inhabitants of Burkina Faso can achieve little without effective and important support from the solidarity of their sister peoples. The industrialised countries should become aware of the fact that the problems of the drainage of the local area, access for all to drinking water and a halt to deforestation require the commitment of all the inhabitants of the earth and not only of Africans. If they do not decide to follow in a determined fashion the path of an authentic and solidarity-inspired sharing, the state of health of the African continent will remain weak and vulnerable. But one must not forget that this situation and the causes that it generates, for example desertification, can have negative consequences for the whole of our planet.

I would like to finish this paper with two quotations: one by a member of the laity and one by the Pope. Bernard Hours, the former President of the World Bank, complained that 'in the world economy there prevails a planetary management of the health care systems under the auspices of the World Bank. According to this management, criteria of profit will be increasingly adopted. The policy of multilateral givers will give way to co-operators who are held to be safe and trustworthy. Soon a non-governmental organisation', concludes Hours, 'will be given the health care management of entire districts and this will not fail to provoke changes in the approach of associations which are concerned with health care development'.

But Christians cannot and must not share this mentality which sacrifices the rights of the human person to that which is useful for that which is useful. The Pope reminds them that 'there is something due to man because he is man, because of his dignity and likeness to God, independently of his presence or otherwise on the market, of what he owns, and thus can sell, and of the means of purchase he has available. This something must never be disappointed but requires rather respect and solidarity (the social expression of love) which is the sole adequate approach to the person.' 'The poor', continues the Pope in his encyclical *Centesimus Annus*, 'ask for the right... to make good use of their capacity for work, thus creating a world that is more just and prosperous for all. The advancement of the poor constitutes a great opportunity for the moral, cultural and also economic growth of all humanity'.

Rev. RENATO DI MENNA, M.I.

The Blessed Luigi Tezza: Founder of the Daughters of San Camillo

On 4 November John Paul II raised to the honour of the altars the Camillian priest Luigi Tezza, founder of the Daughters of San Camillo. Joined to the glorious series of man and woman who, down the centuries, have achieved holiness through the excercise of mercy towards the sick, the new blessed presents himself to the People of God as an original interpreter of the charism of charity towards those people who suffer in the body and the spirit.

Born in Conegliano (Terviso) on 1 November 1842, Luigi Tezza died in Lima on 26 September 1923. His existence was a long, eventful and authentic *pilgrimage in favour of mission*. In fact, he spent forty-two years of eighty-two years of his life in Italy, nineteen in France, and twenty-three in Peru. His activities within the Order of the Ministers of the Infirm (Camillians) took many forms: Luigi Tezza was an educator, a community leader, the founder of a religious Institute, a minister of merciful love towards the sick, the director of souls, and the reformer of religious life.

In Verona and Rome: The Ministry of Training

At the age of fifteen, Luigi Tezza entered the Camillian seminary of Verona and had the good fortune to receive his training in a context where religious life had returned to the original spirit of the founder, San Camillo, with the observation of perfect community life and the exercise of the ministry in hospitals.

He was ordained a priest in 1864 and spent the first years of his ministry as a presbyter in Verona and Rome, where he was involved in the training of candidates for the consecrated and priestly life.

In France: Loyalty and Creativity

He was sent to France in 1871 and contributed in a determining fashion to the development of that foundation, which had been begun two years earlier. During his mandate as Provincial Superior, the French Camillian province of the diocese of Autun was extended to Lyons, Lille, Cannes, Théoule-sur-Mer, and Tournai (Belgium).

Geographical development was matched by creativity and breadth of vision in pastoral choices. Faithful to the Camillian charism, Luigi Tezza did not hesitate to take decisions which were distant from the *letter* of tradition but which remained faithful, however, to its spirit. He agreed with the opinion of one of his mentors to the effect that 'from San Camillo we can and must derive charity, but the means by which to exercise it in our circumstances require that we acquire such means from the special spirit with which the Lord may wish to fill our hearts in order to meet present needs'.[1] A significant example of such discernment of the *signs of times* was the decision that was taken to create and manage their own socio-health care structures. This approach, which was contrary to the tradition of the Institute and the will of San Camillo, was to have consequences throughout the Camillian Order.

The Leadership of the Camillian Order

In 1889 Luigi Tezza was elected Vicar, Procurator and General Counsellor of the Camillian Order. This role enabled him to exercise a positive influence in ensuring that the reform of religious life which had already been carried out in Verona and France could be extended to the whole of the Institute. Thus it was that the perfect community life was approved by the General Chapter of 1898 and looking after sick people in hospitals also regained vigour throughout the Order.

During his period in Rome, which lasted until 1898, he united his responsibilities as Vicar General with intense pastoral activity and founded the Congregation of the Daughters of San Camillo.

Hospitals: My Real Heaven on Earth

Father Tezza was asked to live in the Hospital of San Camillo in Laterano, where he also engaged, part-time, in the ministry of the chaplain. The Camillians had assumed responsibility for spiritual assistance in the hospital in 1836,[2] and had exercised that ministry in an exemplary way.

In this hospital Luigi Tezza was able to exercise the specific charism of the Order with continuity. During the previous years, in fact, it had not been possible for him to consecrate much time to this ministry devoted to the sick because of his tasks and responsibilities at the level of training and in the government of the Order.

The spirit and the methodological directions which guided spiritual accompanying of the sick at that time can be derived from a number of manuals written by Camillian religious. One of these, 'Practica Visitandi Infirmos', published in 1630 by Father Giacomo Mancini – who had known San Camillo personally and who

passed on his spirit in this volume – not only constituted a synthesis of the theory and the practice of the Camillian Order of that time, but had also remained a 'firm reference point for subsequent writings on assistance to the sick'.[3] Indeed, other Camillian authors of the seventeenth century, whose work had an influence on pastoral action until the beginning of the twentieth century, clearly followed on from Mancini.

In the book by Mancini, next to the many indications suggested by the author, which by that time had been superseded, there were a very large number of original and innovative elements.

In very appropriate fashion, Mancini laid stress upon the need for a specific preparation and grounding for the exercise of spiritual assistance to people who are sick. This was, in fact, a ministry that required a good preparation and grounding not only at the theological-moral level but also at the level of actual practice.

If the stress upon the sacramental dimension which is present in the work is relevant, this does not take space away either from a need to have knowledge about the person and his or her needs or from a consideration of the interpersonal and dialogical approaches of the priest. The author invited the pastoral worker to arm himself with prudence and gentleness, and to commit himself to establishing a good relationship with the sick person before proposing prayer and the sacraments to him or her. The tone of voice and the style of conversation are also of importance.

In order to accompany the sick person, preaching or highly complicated theological speeches were, the author argued, not required: what was called for were suggestions marked by a gentle and peaceful tone. The creation of an appropriate atmosphere with music and songs chosen for the purpose, as well as the repetition of biblical phrases centred around the love of the Lord, could also contribute to the effectiveness of the pastoral worker's activity.

The pastoral relationship did not stop at the celebration of the sacraments. Indeed, it had to be continued by the priest himself or by other people.

The vision of Mancini, in which assistance to the sick person is called to be a *ministry of consolation* directed to the whole person, with a view to his or her salvation, certainly found a positive echo in the spirit of Luigi Tezza, both because of his personality and because of the upbringing that he had received. His encounter with sick people was enriched by that sensitivity and emotional warmth that gave colour and contents to his relationship with people he held dear.

The sick people of San Giovanni gradually became the beneficiaries of his *pastoral charity*, which was infused with affection. When asked why during the early morning he opened the window and took in deep breaths, he answered that he wanted to fill his chest with the *scent of charity* which came up to him from the windows of the courtyard below. This action was an echo of San Camillo who, when passing near to the Hospital of the Holy Spirit, stopped to smell its *scent*. In a letter written some years later, Luigi Tezza expressed his regret at 'having left that *hospital, my real heaven on earth*'.

The Daughters of San Camillo

However, the project in which Luigi Tezza invested most of his energies during his period of stay in Rome and which over time was to gain most visibility was the foundation of the Congregation of the *Daughters of San Camillo*.

Cultivated for many years, this initiative was set in motion after a meeting between Giuditta Vannini ('Giuseppina' after her profession), a young woman in search of her own vocation. Together with Giuseppina, Luigi Tezza transmitted the Camillian charism of merciful charity towards the sick and others, who enriched it and broadened it. Indeed, from the 'fertile and blessed trunk' of the Camillian Order there came forth, engaging later in its own independent growth and development, the shoot of a new religious family.

The close link between the Camillian Order and the Congregation of the Daughters of San Camillo did not mean, however, that Luigi Tezza and Giuditta Vannini engaged in a simple transposition of the charism of San Camillo, moving it, so to speak, from one Institute to another.

It is certainly the case that the charism of San Camillo was the great reserve of spiritual energy on which the two founders drew generously for inspiration and to achieve a special approach by which to experience the Lord. But, just as a river comes from a lake and goes down its own and original paths, so the Camillian charism, assimilated by Tezza and Vannini, took on original characteristics thanks to the influence of a large number of factors of a personal, historical and cultural character.

If we limited emphasis to one of the features of this originality, we could say that through the Institute founded by Luigi Tezza the Camillian charism was lived out in a female way, with all that this implied at the level of significance and meaning.[4]

Indeed, San Camillo, when he invited his religious to serve sick people with the heart of a *mother*, had already perceived that care for the sick had to draw upon those qualities and approaches which are typical of the *female genius* – receptiveness, readiness to help, tenderness, welcome, the ability to listen, intuition, sensitivity in understanding situations, the

ability to take on other people's problems, and a propensity to offer help...

One rule that San Camillo drew up is highly significant in this sense: 'First of all everyone must ask thanks of the Lord so that he can give maternal affection to his neighbour, because we wish with the grace of God to serve all the sick with that affection that a loving mother gave to her only infirm son'.

In the Congregation founded by Luigi Tezza this aspect of the Camillian charism was deepened and broadened. He asked his *daughters* to encounter their Spouse in the sick person – is the sick person not an *icon* of Christ? – and to serve him with the heart of a *mother*.

Some phrases from the *Mulieris Dignitatem* of John Paul II allow us to understand the profound nature and the contemporary relevance of the message of Luigi Tezza. If 'God entrusts every man to us all and to each one of use', observes the Pope, 'this entrusting concerns in a special way women – precisely because of their femininity – and it decides in a particular way their vocation' (n. 30). This applies above all in a socio-cultural context in which the successes of science and technology favour uneven progress and thus can also involve a gradual disappearance of sensitivity towards man, towards what is essentially human. In this sense, the Pope continues, our days in particular require the expression of that 'genius' of women which ensures sensitivity for man in every circumstance: because of the fact that he is a man! (*ibid*.)

In bringing into being a new religious Institute, Luigi Tezza offered the Church a strong call to make her concern for people in whom Christ continues to live, over time, his passion, more alive and sensitive.

This is what John Paul II expressed in an enlightened speech to the Daughters of San Camillo: 'Your charism of service to the sick which distinguishes you within the Church, also because of your fourth vow, is a gift and a task that places you at the heart of the life and the mission of the Church, which is a sacrament, a sign, and an instrument, that is to say, of the love of God for the whole man and all men, with special attention for the least, for the sick, and for sinners'.[5]

Is it not the case that the Church needs to develop in an increasingly intense and meaningful way the *Marian dimension*, made up of 'silent nearness in pain', of greatness that becomes welcome and service towards the poor, the weak, the victims of illness and death?

The endeavour of consecrated women is one of the most suitable endeavours by which to respond to this need. 'The Daughter of San Camillo, in fact, represents the Mother Church who welcomes the afflicted and the weak and envelopes them with expressions of concern, who tries with every care to help those in great need, and in them serves Christ himself. In this way she contributes 'to the good and the promotion of the whole human family, whose joys and hopes, sadness and anxieties find echo in her heart'.[6]

Through the presence and work of his beloved *Daughters*, the charism of Luigi Rezza, and of his co-founder Giuseppina Vannini (proclaimed 'Blessed' in 1995), have reached seventeen countries in four continents.

Facing up to the challenges of the world of health and suffering through a variety of ministries, following in the footsteps of their founders, the Daughters of San Camillo now provide an effective contribution to evangelisation through the path of compassionate charity, and are a constant appeal to the presence of Christ in those who suffer.

The Mission to Lima

After his mandate as General Counsellor had terminated, in 1898 Luigi Tezza went back to France. This was a brief stay because two years later he would be called to go to Peru as a general visitor of the Camillian community in Lima.

In the Peruvian capital the Camillians had been present for more than two centuries and had produced a history characterised by good and bad aspects. Always faithful to the Camillain charism, they had dedicated themselves with great ardour to service to the gravely sick and the dying, and were also involved at an academic level in the local city university. Unfortunately, the painful political events of the South American continent and the separation from Rome, effected by the Spanish monarchy, did not fail to give rise to numerous crises and to a certain decline in religious observance.

When in 1897 the Peruvian foundation once again united with Rome, there was the need for the presence and action of somebody who could point out the steps to be taken for a return to a style of life more consonant with religious requirements. Father Tezza was chosen for this mission.

In carrying out this task he drew productively upon the rich gifts of his personality which his long experience in training and government had refined, and he happily harmonised sweetness and firmness, understanding and opposition. The project of reform had a happy outcome, and brought back the Camillian community to its early spirit.

Tezza's project of reform, in fact, was not only directed to those inside the community. He also sought to reconquer the moral prestige that the community had previously enjoyed amongst the population.

Fortified and encouraged by his experience in Italy and France, Luigi Tezza thus committed himself to strengthening the already praiseworthy service that was provided by the religious through helping sick people in private homes, and he also promoted such service exercised in hospitals. He had realised, in fact, that in no place more than Lima was 'our ministry so well understood and appreciated'.

Observing the vast field of work in the world of suffering and health, he drew up an ambitious plan which involved the creation of a chaplaincy which was able to deal with the pastoral needs of the five hospitals and the hospices of the city. This would have allowed a renewal of the prestige of the Order in Lima. The idea won the approval of the ecclesiastical

authorities and the dispatch in 1902 of six brothers of the Order from Europe made this initiative practicable.

The request to have Camillians as spiritual assistants in the hospitals did not have to wait long – the military hospital in 1901; the French and Italian hospitals in 1902; in 1903 the Dos de Mayo with 600 beds; in 1905 S. Anna with 500 beds; and in 1904 the 'Refugio degli Incurabili' with 200 beds. From the 'Casa della Buenamuerte', Camillian charity reached the principal places of pain in order to bring relief to them and guarantee spiritual accompanying.

Assistance in the hospitals was accompanied by assistance in private homes. San Camillo called this sphere of the ministry the *mare magnum*, the vast field of action. In Europe the Camillians were called the 'fathers of dying well'. The name given to the home in Lima – 'the convent of the good death' – emphasised the importance given to providing assistance to the dying, above all in their homes. This was apostolic work which was very demanding given the limited number of religious available. The parish priests themselves willingly left this ministry to the Camillians, and for this reason the calls on their services were large in number and indeed came from 'the four corners of the city'.

Luigi Tezza did not confine himself to strengthening spiritual assistance to the sick people of the city by promoting an intelligent and effective project that involved many health care institutions and an innumerable quantity of homes to be reached. He was also directly concerned with service to the sick and showed that he was at home in this kind of apostolate, even though it was not the ministry which he most practiced.

For 1901 we already have evidence of his ministry in an emergency hospital in the city which took in smallpox and yellow fever victims. He went there every day and put into practice the fourth vow by which he was committed to serving sick people even when this endangered his life. His charity transformed that abandoned place into a 'hidden garden' where he could find relief.

Later on he was active in providing assistance in the Italian hospital and in a prison. From the records of baptisms his presence is also borne witness to in the Dos de Mayo hospital.

This ministry in health care institutions was joined by visits to private homes. From the register of visits for the years 1908-1914, it is clear that he met 1,192 sick people in private homes. At times he even visited eleven sick people a day in different parts of the city.

He did not hesitate to go into the so-called *callejones*, which were the common habitat for most of the population. These were blocks of habitations around a shared corridor at the end of which there was a single source of water and a single lavatory for all the families who lived there. Very often, in these places afflicted by poverty, there abounded alcoholism, ignorance, promiscuity, and fights. The sizeable donations he received from his penitents usually ended up by being given to these abandoned families, becoming food, clothes and medicines.

Spiritual Director

He flanked assistance to sick people with an intense activity of accompanying people through the sacrament of reconciliation and spiritual direction.

Side by side with confessions in the church of the convent and in the hospitals, which occupied him for many hours, he discharged the task of confessor in many female religious institutes and colleges. Archbishop Msgr. Tovar made him spiritual father of the candidates to the priesthood at the 'Conciliar di S. Toribio' seminary.

Many religious and members of the laity looked to him for spiritual direction. He was helped in the carrying out of this ministry both by his personal qualities and his training at the level of doctrine. His sweet and affable character, linked to the soundness of his principles and the prudence of his advice, earned him the esteem and the trust of people. For many witnesses at the process of Lima, the figure and the way of interacting of Luigi Tezza were like those of San Francesco di Sales.

Lastly, there were also affinities with the holy Bishop of Geneva. In both there was the conviction that the effectiveness of the grace of God, transmitted through the sacrament of reconciliation and spiritual accompanying, depended, albeit in a non-decisive way, on the human qualities of the confessor or spiritual director. Acceptance, respect, understanding and compassion, in fact, become transformed into a vehicle of the compassionate love of the Lord, making that love more believable in the eyes of the penitent.

In the Local Church

At the level of the local Church as well, the action of Luigi Tezza was of notable proportions. The prestige acquired with the ecclesiastical authorities is borne witness to by the series of important appointments he received: member of the Council of Administration of the diocese in 1902; Consultor of the Provincial Council of Lima in 1909; member of the Council of Vigilance of the diocese in 1910; and lastly, Theological Consultor of the Bishops' Assembly in 1919, when he was about to reach the age of eighty.

Crossing the Bar

The itinerary of the life of Luigi Tezza finished on 26 September 1923. He breathed his last in a gentle manner after a long illness.

The death of Luigi Tezza had a resonance throughout the city of Lima. Even though he lived in the isolation of infirmity, the number of people attending his funeral was above all expectations. Religious and civil authorities were present, as well as representatives of all the religious institutes.

The passing away of Luigi Tezza was an opportunity to give public expression to acknowledgement of his person and of the holiness of his life. One of the most recurrent phrases to emerge was one which proclaimed that he was the 'apostle of Lima'. Those who had known him best, as a counsellor or spiritual director, did not hesitate to exalt his holiness. The belief that Tezza

had reached the perfection of charity gradually spread in public opinion as well, and this was something which was to resist the passage of time.

On a Journey After Death as well

The mortal remains of Luigi Tezza were transported from the cemetery of Lima to that of Buenos Aires, to the chapel of the community of the Daughters of San Camillo of that city. The convoy which left the capital city of Peru reached Buenos Aires on 24 January 1947, and was received with civil and military honours.

On 15 December 1999 the coffin was moved again, from Buenos Aires to Grottaferrata (Rome), to the General House of the Daughters of San Camillo, where the mortal remains of the Blessed Giuseppina already lay.

This nearness was an evocative symbol of that love which was both humanly rich and spiritually deep and which united these two people in the implementation of a shared project: service to suffering man, the icon of Christ.

The Golden Thread: Spirituality

The life of the Blessed Tezza was eventful and marked by dramatic vicissitudes. In Verona (1866), Rome (1870), and France (1880), he experienced the dramatic moments of the suppression of the religious Institutes. Later on, in Rome, unjust accusations separated him from the Daughters of San Camillo. Furthermore, the work activity engaged in was so intense as to generate dispersion.

Amidst this whirlwind of experiences and work Luigi Tezza managed to *unify* his life thanks to a *golden thread* of rich spirituality.

Only for the Crucified Christ

The background against which should be depicted the whole of his spiritual life was abandonment to the Lord and to his will. Against such a background emerges the Cross, by which Christ implemented the plan of salvation wanted by the Father. The Cross occupied an important area of space in the spiritual life of Luigi Tezza, as it had done in the spiritual life of San Camillo. The founder of the Camillian Order established the fundamental objective of its existence in wanting to live 'only for the crucified Christ'.

What links the human person to the cross is suffering in all its multiple expressions. In the experience of pain, Luigi Tezza saw one of the leading roads by which to unite himself to Christ and imitate him in his love.[7]

In this as well he placed himself in the tradition of his founder. Contact with Franciscanism had indicated to Camillo the road of adaptation to Christ through a life of penitence, as a result of which forms of personal suffering – not only those involved in *the death of oneself* but also those of a physical kind – constitute an effective means by which to imitate the suffering Jesus. Camillo would never abandon this pathway. Indeed, he went ever more deeply into it.

Following the example of the founder, Luigi Tezza constantly linked the negative aspects of his life to the cross – mourning, moments of depression, conflicts both outside and inside the community – in the belief that united to the suffering of Christ they would not fail to bear fruit. This is a recurrent theme of his letters. A theme learnt when he was young and which always remained keenly-felt in his conscience.

Suffering not only unites a person to Jesus but also becomes a source of approaches of compassion, understanding and participation in the suffering of other people, transforming the person into a *Good Samaritan*. From this point of view, the wounded person becomes also a healer.

In Luigi Tezza, as well, were there to be found the fruits of a successful integration of his suffering, and thus he can rightly be defined as being a *wounded healer*, that is to say a person able to transform the personal experience of pain into a source of healing for other people. And this integration of his own wounds should be seen as one of the important factors which helps us to explain his sensitivity towards suffering people.

A 'Heart' Burning with Love

In uniting himself to the crucified Christ, Tezza encountered the source of love, symbolised by the image of the *heart*. The *devotion to the heart of Jesus*, which became strongly felt and practiced during the nineteenth century, thus became an important element in the experience and expression of his spirituality.

He immediately realised that this devotion found a positive resonance in his spirit. Indeed, well anchored in solid theological bases, it also appealed to the dimension of emotions which was so well developed in his personality.

The Heart of Jesus became the *place* where he wanted to live and to grow, finding refuge and consolation at moments of

difficulty, and where there took place the encounter with other people and in particular his *daughters*. His love for them, indeed, 'has as its sole source' the Heart of Jesus, and 'its only nourishment in his inexhaustible love'.[8]

Although there are many ways which allow us to enter the heart of Jesus, that favoured by Tezza was the Eucharist. Through this sacrament the riches of the love of God are transmitted to the human creature, and transform that creature.

Supernatural Love

Devotion to the Heart of Jesus enabled Tezza to develop, albeit in a fragmentary way, a rich spirituality of interpersonal relationships and friendships, something that linked him to the great figures of saints of the past, amongst whom Francesco de Sales. 'In the adorable heart of the Divine Master', he wrote to his *Daughters*, 'may there be our *constant gathering place* where now we can taste beforehand a very sweet taste of the love which beatifies and where I am and I will be for ever'.[9]

Luigi Tezza perceived that when lived in the Heart of Jesus, interpersonal relationships and friendship are infused with supernatural love or *agape*, which does not destroy emotional reality but purifies it and makes it sublime.

Seen in this light, the qualities which characterised Tezza in his interpersonal relationships acquire a totally special significance. The exhortation of Christ: 'Learn from me for I am meek and humble of heart' was the transforming force of his character and his way of living his relationships with other people.

Brotherhood, as experienced by the sisters in their communities, must also drink at the spring of love of Christ: 'Be a single heart and a single soul in the Most Sacred Heart of Jesus. In this union you will always find in abundance consolation, strength, and courage'.[10]

A Contemplative in Action

Union with the Lord, mediated through a deep devotion to the Virgin, achieved through prayer and fostered by a healthy ascesis, led Luigi Tezza to turn towards his neighbour with generous love. The ministry accomplished by him was thus to be seen as a meaningful expression of his spirituality.

In serving the sick, in spiritually accompanying the brothers of his Order and the people who turned to him, he achieved an experience made up of God. In this he found a high mentor in San Camillo, for whom service given to the sick was transformed into an act of worship of God. In the vision of faith of this saint, the sick person became a *sacrament of the presence of Christ*. In him, Camillo saw the wounds of his crucified Lord reopened and causing pain.

This *mystical* dimension of service to the sick made Tezza a *contemplative in action*.

'Point out Holiness'

At the beginning of the third millennium, the invitation of John Paul II to plan the presence and action of the Church in the world 'in relation to holiness'[11] comes forth as courageous and forceful.

An ideal of perfection to which all of us are called, holiness does not involve an exceptional style of life but the ability to live out one's own ordinary life by placing intensely within it the gospel values of justice, peace, reconciliation, and love.

Together with other blessed figures and saints, Luigi Tezza, by his life and his witness, offers a '*high standard of ordinary Christian living*'.[12] Herein is to be found the most valuable aspect of his spiritual legacy.

If because of his life choice, Tezza speaks in particular to consecrated people, his message nonetheless is equally effective for all Christians and men of good will, especially in relation to those of them who are involved in the world of suffering and health.

From his life witness, in fact, come simple and deep messages which find positive echoes in the heart and the spirit of those who in live in contact with suffering and work in favour of the promotion of health.

These are invitations to keep one's humanity alive and warm, to love life and to respect the human person who is made fragile by illness, to find in the generous giving of oneself the reward for one's own action.

To become aware that there is only one answer to the love of God: love.

Rev. ANGELO BRUSCO, M.I.
Centro Camilliano di Formazione, Verona.

Notes

[1] *APL*, 280/274

[2] Cf. M. VANTI, *Cento anni dei CC.RR. Ministri degli Infermi nell'Arciospedale del SS. Salvatore a S. Giovanni in Laterano, 1836-1936* (Rome, 1936).

[3] E. SAPORI, 'L'opera "Practica visitandi infirmos" del Padre Mancini Giacomo M:I – Una proposta di pastorale sanitaria nell'Italia del seicento', in Camillianum 22 (2000), p. 311.

[4] Cf. C. PETRETTO, 'Il femminile del carisma camilliano', in *La vita consacrata nel mondo della salute, gesto e annuncio del vangelo della misericordia* (Quaderni del "Camillianum", n. 4, Rome, 1992).

[5] *Gli insegnamenti di Giovanni Paolo II*, Vol. XLII, 1 (1990), 1991, p. 815.

[6] R. PESCE, 'Le Figlie di San Camillo', in A. BRUSCO and F. ALVAREZ, *La spiritualità camilliana, itinerari e prospettive* (Camilliane, Turin, 2001), p. 422.

[7] Cf. G. TERENGHI, *La croce di Cristo nell'experienza spirituale di San Camillo de Lellis* (Camillianum, Rome, 1996).

[8] *AFSC*, 1A 087.

[9] *AFSC*, 1A 082.

[10] *AFSC*, 1A 064.

[11] *Novo millennio ineunte*, Apostolic Letter at the Close of the Great Jubilee of the Year 2000, n. 30.

[12] *Ibid.*, n. 31.

Pastoral Care in Health

By 'pastoral care in health' we mean the evangelising action of the whole of the people of God, committed to promoting, taking care of, defending and celebrating life, thereby making the liberating and salvific mission of Jesus Christ present amongst us.

In order to carry out this mission, in the Archdiocese of Managua there are two committees which work in a specific way in the field of health and health care. The first is the Archdiocesan Committee for Social Promotion (COPESA), which has health programmes, programmes for community operators, for midwives and obstetricians, for medical care, for the donation of drugs and medicines, and the provision of aid to people who have fallen victim to natural disasters etc.

The second is the Committee for Pastoral Care of the Sick and in Hospitals, which has a pastoral programme for the years 2001-2003.

In the first part of this paper we will dwell upon the work carried out by the Committee for Social Promotion from 1996 to 2001. In the second part we will describe the pastoral programme for 2001-2003 of the Committee for Pastoral Care of the Sick and in Hospitals.

I. REPORT ON THE WORK CARRIED OUT IN 1996-2001

General Aspects

Nicaragua is located in Central America. Its population is estimated to be made up 4,806,700 inhabitants and is for the most part made up of children (45% of the population is under the age of fifteen).

59% of the national territory consists principally of urban settlements (localities which have over a thousand inhabitants and some kind of infrastructure involving forms of social development).

The home is the family unit in which the people of Nicaragua organise themselves in order to meet their moral, spiritual and material needs. 31% of the heads of families are women and it is they who take the main decisions regarding the home. The average family size is 5.5.

Not all homes have hygienic and sanitary services. 64% have access to drinking water through the public system but about a quarter of dwelling places do not possess acceptable sewage systems.

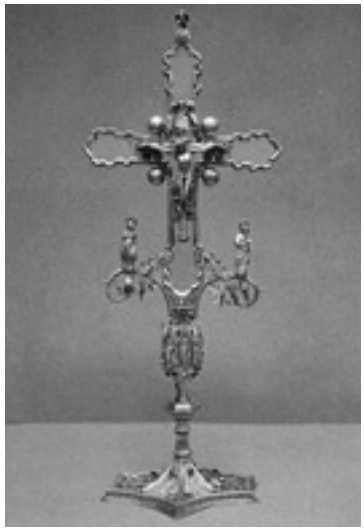
In recent years, the mortality rate of children under the age of five has diminished by 60%. Despite this fact, in the rural areas 32% of children born alive die because of infectious-contagious diseases. Prenatal and birth care is provided by professional staff and personnel only in 60% of the cases of expectant women.

The most common illnesses to afflict children are acute respiratory infections, diarrhea, malnutrition, and skin infections. These illnesses are one of the priorities of the Ministry of Health.

The average level of illiteracy in that part of the population which is over ten years of age is 24.6% and this figure reaches 24.8% in the rural population, and this is a factor strongly associated with the principal causes of illness and death.

Illiteracy or inadequate education are factors which affect the levels of mortality and illness at a general level. This is because they bear upon the perception of illness, the effectiveness of measures of treatment, early recognition of complications, the understanding of instructions, and the ability to read instructions and suggestions.

According to the indices of poverty, 48% of the population of Nicaragua are poor and a part of these, equivalent to 17%



of the population of the country, find themselves below the threshold of poverty.

Public policies implemented during the 1990s had as their objective a reduction in public expenditure in order to diminish the budget deficit. In these conditions, the participation of social organisations in the social field gave priority above all else to basic education in various formal and informal expressions, the control of diseases, preventive health, and nutrition. The goal of the social infrastructure dealing with housing, water, improvement of the marginal urban and rural areas, and the network of social protection, has been to reduce human poverty and to provide temporary assistance centred around extreme poverty.

The Archdiocesan Committee of Social Promotion has as its purpose the promotion of social work and kindred initiatives within the archdiocese of Managua in order to strengthen self-help and to fight against poverty.

Amongst the specific objectives of this committee we may list the following:

– to improve the standard of life of those sectors which are most in need;

– to promote and organise communities so that they are able to take part in a responsi-

ble way in their own growth and development;

– to train leaders for the largest possible number of communities;

– to promote health through the training of community operators and nurses, the provision of medical care, and the giving of drugs and medicines to parish clinics and clinics in rural areas;

– to promote the socio-economic development of poor communities through social projects designed to benefit majorities and implemented under the guidance of community-based organisations.

The Health Programme

This programme revolves around three principal axes of activity: training, medical care, and the donation of drugs and medicines.

The Training of Community Operators

After an analysis of the social situation of our country, training emerged as a priority activity of the programme. It is directed towards the inhabitants of the rural and semi-rural communities of the archdiocese. In recent years 3,500 health care workers have been trained and these people have followed lessons on preventive health, infectious-contagious illnesses, how to prevent them and provide first aid before people seek help from a health care centre, vaccinations, health and the environment, primary forms of treatment, natural methods for responsible fatherhood, care for children, and nutrition (alternative forms of diet and food supply).

These lessons have been given by the medical staff and personnel of COPROSA, of the Ministry of Health, and of the Red Cross of Nicaragua.

In order to obtain the certificate of being a community operator it is necessary to follow a course of 165 hours, at the end of which there are written exams and practical tests at the nearest health units.

This initiative has been a success because this group of people offer their work in prevention days organised by the Ministry of Health, and by working directly in activity involving the promotion of health, the control of diseases transmitted by vectors, and primary health care.

Some of these community operators, thanks to the work that they carry out voluntarily, have been able to increase their own personal growth and thereby have contributed yet further to the good of the community.

The Training of Midwives and Obstetricians

In the rural areas midwives and obstetricians help in 65% of births and thus constitute an important group in the field of health and health care because women in the fertile age turn to them for prenatal care, help during childbirth, and the treatment of their newly-born children. 80% of these midwives or obstetricians are over sixty-five years of age and practice natural medicine.

Given their importance within the community, three groups have been formed in the different departments of the archdiocese - Managua, Masaya, and Carazo. They deal with the provision of materials which are periodically substituted to help during childbirth, provide lessons on the growth and development of the embryo, normal pregnancy, illnesses during pregnancy and signs of risk, care during childbirth and care for the newly-born child, the promotion of maternal breastfeeding alone, the importance of vaccination, and changing attitudes and customs which endangers the health of the mother and the child. Indices of reference have been established with the health units, they have taken part in analyses of the deaths of mothers and of children in the field of health care they are concerned with, and they have also participated in initiatives directed at prevention.

Visits are organised with midwives and obstetricians to the homes of women who have pregnancies at risk and who do not want to take advantage of the health service. In this way, the mortality rates of mothers and children have been reduced in the communities where they live.

Medical Care and the Donation of Drugs and Medicines to Parish Clinics

Medical care is provided by fifty-six parish clinics, most of which are administered by priests, members of female religious orders, parish committees or church movements. Each of these clinics has laboratory services, dentistry, medical care, and specialised treatment. All activity in these spheres is carried out by medical doctors who work voluntarily or for payments made to them by some of the patients. These payments amount to one American dollar.

Medical care is provided, drugs and medicines are supplied, educational conversations are held, and food complements are distributed to people suffering from malnutrition, to elderly people, and principally to children.

In some cases, programmes involving clinical support are implemented for people afflicted by chronic illnesses such as asthma, arthritis, arterial hypertension, and diabetes. In these educational programmes people are divided according to the illnesses involved, and they receive basic information about their afflictions and about how to live with and avoid complications.

These programmes include educational material, conversations, alternative forms of nutrition, medical consultation, drugs and medicines, and laboratory tests.

The Donation of Drugs and Medicines

We receive drugs and medicines from Americares, an American non-profit making foundation whose principal activity involves the donation of drugs and medicines to a hundred and thirty countries in the world. In addition to drugs and medicines, this organisation also supplies us with material which has to be substituted periodically and food supplements.

We also receive help from Action Medeor, a German or-

ganisation that gives drugs and medicines and materials which have to be substituted periodically. This was done, for example, at the time of the hurricane Mitch and the Masaya earthquake of July 2000.

The Aid and Help Provided by COPROSA to the Victims of Natural Disasters

In the middle of 1998 COPROSA organised discussion laboratories in the parishes along the shores of Lake Managua. The subjects addressed were civil defence and organisation in cases of natural disaster, among others. As a result, when the hurricane Mitch struck the country the local population was able to co-ordinate the evacuation and thereby avoid the loss of human life.

At the archdiocesan level, the places struck were the coasts of Managua, Mateare, Tipitapa, and San Francisco del Carnicero, Asentamiento Humano Nueva Vida implemented its overall programmes of sustainable human growth and development.

Medical care and drugs and medicines were directly provided to the people who had been afflicted by the disaster and this took place during the six months that followed the hurricane. Amongst these people were found individuals afflicted by illnesses such as maladies of the respiratory tract, diarrhoea, skin diseases (fungi, impetigo), nervous disorders etc. Food, drugs and medicines, and clothes were distributed to 3,340 families.

Courses of preventive medicine were given, during which subjects were dealt with such as the prevention of transmissible diseases, how to deal with garbage, education as regards the environment, reafforestation, sexually transmitted diseases, and education in natural methods of family planning.

Groups of community workers were organised in each of the localities which had been struck, and at the present time these act with the nearest health units in matters relating to vaccinations, hygiene, and the transfer of sick patients to health centres.

Various international organisations (Caritas) have been asked to supply help to build decent homes, for reafforestation, for medical care, for education in relation to the environment, and for courses of technical training (sewing, beauty care, carpentry).

The mechanism employed to build such homes has been the participation of the local community in the form of manual labour.

At a national level, COPROSA has provided help through the provision of drugs and medicines, clothes and food supplies to the principal departments hit by natural disasters: Chinandega, Matagalpa, Leon, Esteli, Boaco, Chontales, Jinotega and the Atlantic coast.

II. THE PASTORAL PLAN FOR 2001-2003

Introduction

Man is called to joy, but he has a daily experience of very many forms of suffering and pain. The Church shares in the suffering of her sick brothers and sisters, and invites her children to join their illness to the redemptive passion of Christ. The Church counts on you to teach the whole world what love is. 'We will do everything we can so that you may find your rightful place in the Church and in society' (*Christifideles Laici*, 53).

The Church, which 'was born from the mystery of the redemption on the cross of Christ, is called to search for her encounter with man in a particular way on the way of suffering. In this encounter man becomes the way of the Church, and this is one of the most important ways' (*Salvifici Doloris*, 3). The man who suffers is the way of the Church because above all else he is the way of Christ himself, the Good Samaritan, who 'did not pass by' but had compassion and 'drawing near saw his wounds' (Lk 10:32-39) and took care of him.

It is a matter of urgency and necessity that the inheritance that the Church has received from Christ, 'physician of the body and the spirit', is increasingly appreciated and enriched through a return to, and the implementation of, decisive diocesan pastoral action for and with sick people and those who suffer, both when they are in hospitals and when they are in their beds at home, through pastoral care for people who are sick at a parish level.

In this renewed pastoral action one of the fundamental objectives is 'to look upon the sick person, the bearer of a handicap, or the suffering individual, not simply as an *object* of the Church's love and service, but as an *active and responsible participant in the work of evangelisation and salvation*' (*CL*, 54).

To be a diocesan Church, in addition to being a gift of God, is also a beautiful task to perform. For this reason, our Church must be a constant servant of the Kingdom of God, proclaiming that Kingdom and making it present in our reality, responding to what is most urgent, suitable and effective at any given moment as a salvific response of God to harsh reality, in favour of men and women loved by Him, and especially those who suffer in the body and the spirit.

The Church proclaims and offers salvation through preaching and sacramental life, but also through the invisible effectiveness of her pain. For this reason, as mother and teacher, she is not extraneous to the suffering of her children: 'the joys and the hopes, the sadness and the worries of men are also the joys and the hopes, the sadness and the worries of the Church' (*Gaudium et Spes*, 1.).

Pastoral care for sick people

and pastoral care carried out in hospitals is one of the forms taken by the presence of the Church in her preferential option in favour of the poor. His Holiness John Paul II has said that hospitals are privileged places to know and love Jesus in the pain and the meekness of every person.

In our archdiocesan synod pastoral care for the sick and in hospitals has as its general objective:

– to evangelise the hospital world of the archdiocese in the light of the Gospel, co-operating in the formation of consciences in the experience of faith and human promotion with a view to forming Christian communities.

The specific objectives of this pastoral care are:

– to proclaim the message of the Gospel in hospitals and to the sick people in them, placing emphasis on the love of God for sick people;

– to foster and co-ordinate visits to sick people in hospitals at the parish and archdiocesan levels;

– to reach the heart of sick people both in parishes and in hospitals through the Eucharist, the centre of our faith and actions in the life of every sick person.

The Work Plan for Pastoral Care of the Sick and in Hospitals

Hospital pastoral care must be animated by suitable people who have the vocation and the due grounding and training to provide these services in hospitals, in lunatic asylums, and in leper colonies.

Parishes, the places of encounter where Christians live out their communion and overcome the limitations of their small communities, and where through the Eucharist the practice of the simple charity of good and brotherly works with feelings and in daily life is taught, are called to bear witness to love for sick people. For this reason, pastoral care for the sick at a parish level has as its general objective:

– to support in an emotional and effective sense members of the laity in parishes to live out Christian solidarity with those people who experience particular situations of suffering and especially the sick.

The specific objective is:

– to promote programmes illuminated by the Magisterium of the social teaching of the Church in order to sensitise and educate members of the active laity and other groups of the parishes in relation to an awareness of the need for support and solidarity towards sick people admitted to hospitals.

Practical Lines of Action

a) The Promotion and Consolidation of Pastoral Care for the Sick in Parishes

– the organisation of teams who will visit all the sick people in the local parish. To this end, pastoral care for sick people in the parishes will encourage and promote teams of pastoral care for the various districts into which our archdiocese is organised;

– the drawing up of a map by areas and sectors of homes which have sick people so that they can be easily identified by the local priest, by pastoral workers, and by ministers of the Eucharist.

b) The Planning of a Strategy of Care for the Sick

– The classification of sick people on the basis of their illnesses and their basic needs.

– The promotion of the Catholic faith and conversion through the word of God so that through prayer and the sacraments sick people can improve their health or accept their situation as sharing in the suffering of Christ, in communion with all those who suffer for a variety of causes.

– The establishment of a calendar of visits to sick people by sectors in which are set down the hour and the day of these visits.

– The organisation of 'missionary pastoral care for sick people' in relation to sick people and the entrusting to them of specific tasks of intercession through prayer in ordinary or extraordinary activities carried out in parishes or through the various functions of the life of the Church.

– The organisation of pastoral care involving comfort and consolation which can reach all the members of the parish who experience situations of suffering: invalids, abandoned elderly people, and families worried about the illness or the death of a loved one.

c) The Training of Pastoral Teams Composed of Sick People

– The training of active members of the laity both at the parish level and at the level of the different areas; the organisation of meetings of these pastoral parish teams through training in catechesis, the study of Church documents, the organisation of pastoral care, humanitarian initiatives, retreats, and assemblies.

– The training of extraordinary ministers of the Eucharist, catechism, and the celebration of the word directed in particular towards sick people.

– The accompanying of the sick in their loneliness so that they feel the peace, the comfort and the love of God through the emotional and charitable solidarity provided by the parish community.

– The promotion and fostering of the participation of the laity in the hospital pastoral care of the archdiocese (organised by areas).

Specific Tasks at the Parish Level

– The co-ordination of activity with other pastoral ministries: the parish clinic, ministers of the Eucharist, pastoral care for families, youth com-

munities, and social pastoral care.

– The maintenance of contacts with the parish priest for the administration of the sacrament of reconciliation, the anointing of the sick, the Eucharist for those who ask for it and those who need it.

– The evangelisation in addition to the sick person of his or her family so that they, too, feel the special presence and strength of God in the most difficult situations of life and death.

– The co-ordination of various activities with sick people: the celebration of the world day of the sick of 11 February, the celebration of the Eucharist with sick people in the parishes, and various celebrations that are directed towards pastoral care for sick people.

– The acquisition of basic knowledge about illnesses and diseases so as to be able to take the necessary precautions in relation to our sick brethren without falling into a condition of apathy or indifference.

– To help sick people, where this is possible: the creation in parishes of a specific day for the celebration of the Eucharist, and a day of charity for sick people so as to help them in relation to any basic needs that they may have.

Pastoral Care in Hospitals

The Church has good news to ring out within the world of hospitals, which are 'places of suffering', above all in a hedonistic society which has lost the meaning of human suffering and censures all talk about this hard reality of life. 'The proclamation of this good news gains credibility when it is not simply voiced in words, but passes into a testimony of life, both in the case of all those who lovingly care for the sick, the handicapped and the suffering, as well as the suffering themselves who are increasingly made more conscious and responsible of their place and task within and on behalf of the Church' (*CL*, 54).

We urgently need well-organised pastoral care in hospitals. This has already begun to bear fruit in the lives of those who work in such institutions. Today in our hospitals there are large numbers of the lay faithful, men and women, who make Jesus, the Good Samaritan, be present in the sick and those who suffer, revealing and communicating the love of care and comfort of Jesus Christ.

The General Objective

To bring the Gospel into the various hospitals of our archdiocese so that in the light of the Gospel is expressed the love of Christ and the Church for sick people, as well as Christian solidarity towards all those men and women who suffer in body and in spirit.

Specific Objectives

– To proclaim in hospitals the message of the love and hope of Jesus to those who suffer.

– To foster and co-ordinate pastoral work together with priests and active members of the laity.

Practical Lines of Action

a) The promotion of Pastoral Care for Sick People in Hospitals

– The organisation of religious activities within hospitals: weekly visits, care for the sick person through confession, the anointing of the sick, and the celebration of the Eucharist in every hospital.

– The organisation of small teams of lay people to visit sick people in hospitals together with priests, to encourage them, and to be near to them.

– The involvement of the lay faithful of the parishes near to hospitals as a part of the commitment with the Lord to the apostolate for the sick of their parishes.

b) The Planning of a Strategy of Care for the Sick

– The promotion of the faith of the Church and the conversion of sick people through the proclaiming of the word of God so that with prayer and the sacraments they can improve their state of health or find the strength to know how to accept suffering as a moment of encounter with the Lord.

– The drawing up of a calendar of visits to hospitals, by area, establishing the day and the hour of each visit so that priests and members of the laity can dedicate time to meeting sick people.

– The organisation of pastoral care for the sick and in hospitals by small groups of members of the laity who have the specific task of interceding with prayer for all the sick people of the hospitals and the parishes.

c) The Training of Teams of Members of the Laity to Visit Hospitals

– Accompanying the ministers of the Eucharist through permanent training on the role that they play in their work with sick people when bringing them the Eucharist.

– The training of members of the laity who visit sick people through meetings organised along the lines of the pastoral areas so that they play a preponderant role in the lives of sick people.

– Working with the medical and hospital staff through conferences, retreats, seminars, sermons, and the Eucharist.

Specific Tasks

– The co-ordination of pastoral activity to the benefit of sick people with other ministries of the diocese: the apostolate of the sick, the ministries of preaching, the pastoral care of families, pastoral care for young people, and social pastoral care.

– To provide assiduous assistance to sick people through the administration of the sacrament of reconciliation, the Eucharist, and the anointing of the sick for those who need this last sacrament.

– The acquisition of basic knowledge about illnesses so that the necessary precautions can be taken during visits to sick people in hospitals.

– The provision of help to sick people or hospitals in relation to basic needs such as pyjamas, drugs and medicines, food, etc.

The Archdiocese of Managua, Nicaragua.

The World Day of the Sick 'Praying in Illness', 11 February 2002: Guidelines for Pastoral Care in Health - Spain

Why Have We Chosen this Subject?

1. Illness is one of the 'fundamental events of existence (*Dolentium Hominum*, 2), a complex experience that is in contrast with the wish to live, that demonstrates human fragility and caducity, that leads those who experience it into a world full of questions, a world which is different and foreign.

2. All of us can fall ill. For this reason, we must be aware of this reality and live with the prospect of illness in mind, knowing that illness invokes freedom and meaning, that it can be experienced as an opportunity and a challenge or as negativity, and that it can also be ignored or denied, as though it never knocked at out door.

3. In experiencing illness, in the same way, it is possible that the person discovers in a more radical way his or her own rooted loneliness and limitations, the specific condition of being unique and irrepeatable, and thus the challenge of our responsibility towards illness. In this situation, which often implies a break with ordinary life and a certain uprooting, questions of every kind are often asked: some of these involve searching for reason; others ask for an answer; yet others look to the past; others, in contrary fashion, look to the future. It is probably the case that in all these questions there is reflected the original and privileged condition of man: a being, that is to say, who is open to transcendence, and at the same time who is woven into fragility, who is both poor and capable of fullness.

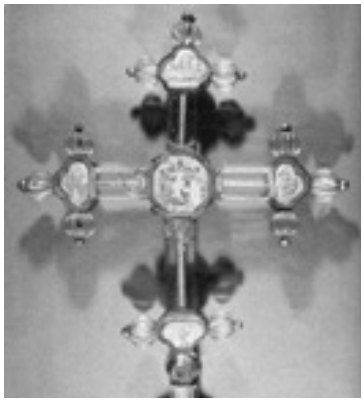
4. A period of illness, whether chronic or acute, of varying degrees of gravity, is a time of worry, of shadows, and of hope, in which everything is subjected to trial. In living out illness, man experiences his limits and often new opportunities as well. This is a time lived out in another way. At times, a time of grace, of encounter with one's own truth and that truth of He in whom we live, we move and we exist.

5. God did not want to abandon man in the face of suffering and illness. Holy Scripture tells us about great people of prayer who during their lives experienced moving through 'deserts'. In Jesus, our pain becomes attentuated and our hopelessness becomes transformed into the Good News. The glorious cross of Jesus Christ marked the victory of God over pain, over illness, and over death.

6. The history of salvation and of Christian spirituality, yesterday and today, presents us with men and women who, in the realism of their lives, have become aware of their own being, allowing God to be the God of their lives. In hidden teaching, in the experiences of adversity, God revealed his face and his plan of salvation to them. They did not ask to be saved from suffering and illness, but to be saved in them, thereby finding grace in misfortune.

7. *Praying in illness* has been a constant feature of the faith proclaimed and celebrated by the Church. It has always been present at the moment of illness. Thus, a liturgical tradition of the Church at the margins of this existential situation is unthinkable, and around this situation a whole spirituality has been developed and lived out with emphasis being placed on the various dimensions and forms of prayer. For many believers this time has been, despite everything, an opportunity to renew weakened faith and once again accept the ecclesial offer of salvation.

8. *Praying in illness* certainly raises new challenges of every kind, but it is no accident that prayer is influenced by a whole variety of factors. The world of health and health care and illness is a good case study of these influences. For many people, prayer has stopped being 'interesting' because it is no longer 'useful'; for others, prayer continues to be a private and very personal question. Prayer should be evangelised and purified so that it accompanies, stimulates and opens up paths for the thirst for God, for the strong wish for fullness and salvation which lives, at times unknown, in the hearts of many people.



9. *Praying today in the world of illness* has a particular importance within the evangelising mission of the Church. Her immense salvific, health-giving and therapeutic richness is expressed specifically in charity and prayer, in witness and celebration. Sick people and their families, the professionals of health care and voluntary workers, pastoral agents and the Christian community, are all called to discover once again – and despite everything – that the God of Life is a God who heals and saves, who leads man to his fullness, and that a time of illness is also a time of salvation.

10. The campaign of the World Day of the Sick should be experienced, therefore, as an opportunity for grace to ensure that pastoral care in health renews the faith of all

its members in the salvific and health-giving effectiveness of prayer, and at the same time strengthens their capacity to accompany people in prayer during illness.

Objectives

1. To reflect, beginning with different perspectives, on the meaning, the value and the questions and issues of prayer in illness.
2. To gather together and analyse the various experiences of prayer in illness, seeing it in the light of the great people of prayer of the Bible and Christian spirituality.
3. To illuminate and motivate, in the Light of the Gospel, of the liturgical practice of the Church and of the experience of belief, the therapeutic and health-giving dimension of the life of prayer of the believer and the Church.
4. To analyse and look again at liturgical and sacramental pastoral activity in the world of health and illness, paying special attention to its intrinsic dimension of prayer.
5. To offer those means suitable to fostering growth in the life of the Spirit and to help and to accompany other people to 'pray in illness'.

The Materials of the Campaign

– Pamphlets and slogans relating to 'prayer in illness'.
– Prayers in printed form.
– The Message of the Bishops of the Episcopal Commission for Pastoral Care.
– Materials for education in the faith and subjects dealing with training.
– A guide for the liturgy of the day.
– The book 'Prayer in Illness'.
– The monographic edition of *Labor Hospitalaria* on the subject.

Those for Whom such Materials are Intended

– The sick.
– The Christian community and teams working in pastoral care in health.
– Religious congregations.
– Health care and socio-health care institutions.
– Voluntary workers (both men and women) and voluntary work groups/associations.
– Health care staff and personnel in general.
– Faculties of theology and Institutes of pastoral care.
– The training centres for future Christian professionals.
– Society in general.
– Communities dedicated to the contemplative life.

Activities at a National Level

1. To dedicate the central part of the National Days of Pastoral Care in Health (Madrid, September 2001) to the subject 'prayer in health', in line with the principal contents of these 'Guidelines'.
2. To organise round table conferences or other kinds of initiatives (of the Church or other institutions) within the mass media where experts on the subject will be present.
3. To publish a monographic edition on the subject in the journal *Labor Hospitalaria*.

Praying in Illness

The Department of Pastoral Care in Health has reflected on the subject of prayer in illness with the diocesan delegates, this subject being the central theme of the World Day of the Sick in Spain. The deliberations were opened by the Bishop responsible for pastoral care in health, H.E. Msgr. Rafael Palmento, with the following short speech:

'"Why do we suffer? What do we suffer for? Does the fact that people suffer have a meaning?", the Pope asked in 1979 during his visit to Mexico, next to the Virgin of Guadalupe. And he answered in a loud voice: "pain is a mystery, at times not penetrable by reason. It is a part of the mystery of the human person, and it becomes clarified only in Jesus Christ..."

In fact there are many questions, which on so many occasions we direct to the Lord, to which we must offer answers. And clear answers, because pain is a mystery. It would cease to be such if we understood it and could explain it. In the face of mystery we must have an approach of faith, which is simple and responsible and never in conflict with reason: 'Faith and reason are like two wings on which the human spirit rises to the contemplation of truth'"

The Mystery of Suffering and Illness Must be Illuminated Taking Faith as a Point of Departure

In his first encyclical (*Redemptor Hominis*), the Holy Father observed that Jesus Christ reveals to man what is specific to man, and that the whole of the life of Christ has a pedagogic value for us because it teaches us to address ourselves to every situation taking the Gospel as our point of departure.

A constant element in the life of men and women of all ages has been and will continue to be the cross. Always present, sewn into our earthly, finite and mortal existence. How should we face up to this reality? Where should we learn to 'deal with the cross'? For those people who are inserted into the Mystery of Christ and for all our other brothers and sisters called one day to be so, the answer is the Crucified One. The Cross of Jesus illuminates the mystery of the illness and the suffering of all men.

Prayer: Embracing the Cross of Christ

Trusting prayer is a privileged means by which to nourish the faith that we profess. We pray to establish ties of union with the Lord, an affective and effective union. Through prayer we enter more deeply into the Mystery of Christ, he who through the Spirit of the Father and the Son gives to us the gift of faith. Prayer draws us closer to the three divine Persons: to the Father, to the Son, and to the Holy Spirit. Indeed, we unite ourselves to God through love, and this love helps us to align ourselves to the full with the mystery of Christ, and in particular with the mystery of the Cross. To pray, therefore, means to embrace the cross. It means to learn to take it on one's shoulders and to walk with strength at the side of

Christ, the path of Calvary, that is to say the hill of salvation, of the source of life.

The Blessed Manuel Gonzalez, the Bishop of the Eucharist, without anything or anybody, prayed as follows during his moments of adversity and trial:

Take up your Cross

Take it up...it is pain, illness, humiliating contempt, an omission, a slander, an absence, a bad interpretation of my intentions, an example of ingratitude.

Jesus, my nature has been shaken; but your presence in me and the certainty that you will not burden me with more than you have decided give me courage in order to answer in peace: I will accept it.

In the hours of this day which are lengthened by the cross, when my lips open up to utter a cry of lament, a protest, I will remember the voice which says to me: take it up, and from the hands that will offer it to me; and peace, and at times joy, will go on being the companions of my cross.

Heart of my Jesus, I want to receive your crosses with joy and peace, because I know that they are made to measure by the good hands of God my Father.

Say to my soul: I am health[1]

In Illness and Pain, Beseeching Prayers

All those people who see themselves as poor and in need have to stretch out their hands. Jesus himself says this in a strong fashion in the gospels: "Ask and you will be given..." Often there are men and women afflicted by different illnesses who turn to the Messiah to find a remedy for their maladies. At other times intermediaries act to ask the Master to heal a loved one. And we always find the Lord who comes to meet our needs: moved, at times, by a cry for help, and at others looking *'de officio'* for those who need him. Jesus always serves the sick person. St. Augustine assures us: 'the Lord, too, serves his sick servants so that he can have servants who serve him; he serves sick people until they are healed. Our Lord serves the sick' (*Sermon* 265 F, 1).

In the Gospel according to St. Matthew (15:21-28), we find a paradigm for beseeching prayer in illness. A Chanaanite woman drew near to Jesus to ask him to act on behalf of her sick daughter. Hers was a fine lesson. She insisted without becoming discouraged. And the Lord, who appeared not to have listened, acted. Here we are taught, and such is the commentary of St. Augustine, 'to move upwards beginning with humility... She cried out with anxiety to obtain a beneficial action, and called with force; he dissimulated, not to deny mercy, but to stimulate the wish, and not only to increase the wish, but to recommend humility. She cried, therefore to the Lord who did not listen but instead planned in silence what he was going to do' (*Sermon* 77,1).

Not Only Supplication but also Worship, the Action of Grace and Praise

St. Ignatius di Loyola, in the meditation 'Principle and Foundation' of his Exercises, observes: 'man is created to praise, revere and serve God our Lord, and through this save his soul'(23). The goal of every man, whether healthy or sick, is thus to praise God.

The poverty which in human terms is involved in illness is without any doubt a form of wealth that joins us to God. This is what we see in the saints and in so many people who live with real joy in their pain, when there is a motivation which gives meaning to illness and pain, 'I feel an immense joy', wrote the Blessed Rafael, a Trappist monk, 'that I can suffer for Jesus, of a kind I never imagined'.

Praying in Illnesses of the Soul as well

In these moments as well we need support, the help of another person, and the healing that has been asked for. 'Could we heal ourselves', asks St. Augustine. And he answers: 'We are capable of wounding ourselves, but who of us is able to heal the wounds that have been inflicted?...Nobody can heal merely by wanting to do so. Let your soul be pious, be faithfully Christian, and do not be ungrateful with grace. Acknowledge the physician. The sick person can never cure himself' (*Sermon*, 170, 7).

Praying for and helping the healthy and the sick, for believers who want to be consistent and coherent, is the firm support upon which the objectives of pastoral care in health rest, and these objectives have recently been formulated in the following terms:

– to illuminate the mystery of illness and suffering taking faith as a point of departure;

– to evangelise the world of the culture of health and health care;

– to accompany the sick;

– to celebrate the sacraments of infirmity.

Yes, brothers, trusting and persevering prayer while we are alive. 'I already knew from the Gospel', and here we return again to St. Augustine, 'how the Chanaanite through her perseverance achieved (for her own daughter) what she could not obtain by asking for it only once...More than the health of a daughter we are dealing here with the immortality of life. It is this that we should ask right up to the end, so that we can live without end where there is no asking but exultation' (*Sermon*, 7 B,1).

The Department for Pastoral Care in Health, Spain

Note

[1] F. C. CHAVES, *Orar con el Obispo de la Eucaristia* (Burgos, 1998), pp. 162-3.

The future of Obstetrics and Gynaecology

The International Meeting of Catholic Obstetricians and Gynaecologists Organised by the World Federation of Associations of Catholic Doctors (FIAMC) and MaterCare International (MCI)

Rome, 17-20 June 2001

DOLENTIUM HOMINUM N. 48-2001

Address of Presentation

Holy Father,

The International Meeting 'The future of Obstetrics and Gynaecology' organized by the World Federation of Catholic Medical Associations and by MaterCare International on 'The Fundamental Human Right to Practice and be trained according to Conscience' has gathered in Rome specialists of this discipline from 40 countries of the five continents.

Without any solid organization, 140 doctors came from all over the world and we had to refuse applications because of lack of space.

This kind of spontaneous answer, testifies that the problem is deeply felt by obstetricians. In fact, the changes which have occurred in this discipline over the last 40 years, after contraception, abortion, i*n vitro* fertilization and embryo manipulations have become widespread, have created a profound discomfort, while ideological, political and professional pressures to abandon any moral conflict have caused a sort of social ostracism of those specialists who intend to keep faithful to the teachings of the Church.

As a consequence, the number of Catholic obstetricians is decreasing continuously and we are afraid that the respect for human life, the moral attitudes of Catholic women, the pastoral care of marriage and of families, and teaching and future research in the field of human reproduction could be deeply affected.

The meeting, which started this morning, will address the main theme from the different constitutional, legal, professional and moral perspectives, and the implications for the different aspects of the pastoral care of the Church will be outlined by authoritative interventions of the dicasteries and institutions of the Holy See related to the problem. In addition, free communications will describe the situation in different countries and particularly painful personal experiences will be presented.

We know, Holy Father, that the problem is partitularly close to your heart. In *Evangelium Vitae* (n. 74) you invited the legislators to acknowledge and protect the basic human right of physicians to fulfil their moral duty of refusing to take part in committing actions intrinsically incompatible with human dignity. Not only aware that a formal recognition of the rights of conscience can be insufficient and sometimes meaningless, you asked that 'those who have recourse to conscientious objection must be protected not only from legal penalties, but also from any negative effects on the legal, disciplinary, financial and professional pla ne' (*Evangelium Vitae* n. 74).

We would like to thank you for which *Evangelium Vitae,* which we consider the *Magna Carta* of human living together and, for this reason, a great social Encyclical Letter even before being a great moral teaching.

We would like to thank you also for the support you are giving to the struggle of all those who defend and promote human life.

For those submitted to a sort of social ostracism, your appreciation is a source of courage, strength and human dignity.

Thank you, Holy Father, also for the special audience you have granted us today. It is another sign of attention for the special problems we experience in our daily witness.

We are eager to hear your voice suggesting possible actions in defence of the basic human right of obstetricians and gynaecologists to be trained and to practice according to conscience. We ask, Holy Father, your blessing on our activities.

Dr. GIAN LUIGI GIGLI
President of the World Federation of Catholic Medical Associations (FIAMC)

Doctors Protest Conscience Discrimination

THE HOLY FATHER'S ADDRESS TO THE INTERNATIONAL CONGRESS OF CATHOLIC OBSTETRICIANS AND GYNAECOLOGISTS, ROME, 18 JUNE 2001

Distinguished Ladies and Gentlemen,

1. I warmly welcome your visit on the occasion of the 'International Congress of Catholic Obstetricians and Gynaecologists', at which you are reflecting upon your future in the light of the fundamental right to medical training and practice according to conscience. Through you, I greet all those health workers who, as servants and guardians of life, bear unceasing witness throughout the world to the presence of Christ's Church in this vital field, especially when human life is threatened by the burgeoning culture of death. In particular, I thank Professor Gian Luigi Gigli for his kind words on your behalf, and I greet Professor Robert Walley, co-organizer of your Meeting.

Certain Advances Create Problems for Medical Ethics

2. Christian obstetricians, gynaecologists and obstetric nurses are always called to be servants and guardians of life, for 'the Gospel of life is at the heart of Jesus" message. Lovingly received day after day by the Church, it is to be preached with dauntless fidelity as "good news" to the people of every age and culture' (*EvangeliumVitae*, n. 1).

But your profession has become still more important and your responsibility still greater 'in today's cultural and social context, in which science and the practice of medicine risk losing sight of their inherent ethical dimension, [and] health-care professionals can be strongly tempted at times to become manipulators of life, or even agents of death' (*ibid.*, n. 89).

Until quite recently, medical ethics in general and Catholic morality were rarely in disagreement. Without problems of conscience, Catholic doctors could generally offer patients all that medical science afforded. But this has now changed profoundly. The availability of contraceptive and abortive drugs, new threats to life in the laws of some countries, some of the uses of prenatal diagnosis, the spread of i*n vitro* fertilization techniques, the consequent production of embryos to deal with sterility, but also their destination to scientific research, the use of embryonic stem cells for the development of tissue for transplants, to cure degenerative diseases, and projects of full or partial cloning, already done with animals: all of these have changed the situation radically.

Moreover, conception, pregnancy and childbirth are no longer understood as ways of cooperating with the Creator in the marvellous task of giving life to a new human being. Instead they are often perceived as a burden and even as an ailment to be cured, rather than being seen as a gift from God.

Gospel of Life has to Influence Idea of Reproductive Health

3. Inevitably Catholic obstetricians and gynaecologists and nurses are caught up in these tensions and changes. They are exposed to a social ideology which asks them to be agents of a concept of 'reproductive health' based on new reproductive technologies. Yet despite the pressure upon their conscience, many still recognize their responsibility as medical specialists to care for the tiniest and weakest of human beeings, and to defend those who have no economic or social power, or public voice of their own.

The conflict between social pressure and the demands of right conscience can lead to the dilemma either of abandoning the medical profession or of compromising one's convictions. Faced with that tension, we must remember that there is a middle path which opens up before Catholic health workers who are faithful to their conscience. It is the path of conscientious objection, which ought to be respected by all, especially legislators.

Never Cooperate Formally in Evil

4. In striving to serve life, we must work to ensure that the right to professional training and practice that is respectful of conscience in law and in practice is guaranteed. It is clear, as I noted in my Encyclical *Evangelium Vi tae*, that 'Christians, like all people of good will, are called upon under grave obligation of conscienee not to cooperate formally in practices which, even if permitted by civil legislation, are contrary to God's law. Indeed, from the moral standpoint, it is never licit to cooperate formally in evil' (n. 74). Wherever the right to train for and practice medicine with respect for one's moral convictions is violated, Catholics must earnestly work for redress.

In particular, Catholic universities and hospitals are called to follow the directives of the Church's Magisterium in every aspect of obstetric and gynaecological practice, including research involving embryos. They should also offer a qualified and internationally recognized teaching network in order to help doctors who are subject to discrimination or unacceptable pressure on their moral convictions when specializing in obstetrics and gynaecology.

Church's Mission to Support Obstetricians, Gynaecologists and Health Workers

5. It is my fervent hope that at the beginning of this new millennium all Catholic medical and health care personnel, whether in research or practice, will commit themselves whole-heartedly to the service of human life. I trust that the local Churches will give due attention to the medical profession, promoting the ideal of unambiguous service to the great miracle of life, supporting obstetricians, gynaecologists and health workers who respect the right to life by helping to bring them together for mutual support and the exchange of ideas and experiences.

Entrusting you and your mission as guardians and servants of life to the protection of the Blessed Virgin Mary, I cordially impart my Apostolic Blessing to you and to all who work with you in bearing witness to the Gospel of life.

The International Meeting of Catholic Gynaecologists and Obstetricians: The History of an Event

One hundred and forty Catholic gynaecologicsts and obstetricians from over forty countries of the five continents of the world, called together by the World Federation of Associations of Catholic Doctors (FIAMC) and MaterCare International (MCI), met in Rome for four days from 17 to 20 June 2001 to discuss the future of their profession. The focus of the meeting, which was organised together with the Pontifical Council for Health Pastoral Care, was the fundamental human right to practice a profession and to be trained in a way that respects one's own ethical beliefs.

The response to the call was enthusiastic and all the participants expressed almost a feeling of liberation at the fact that they could at last talk about their own difficulties and condemn the pressures (and at times forms of oppression) that they have to undergo.

Some sentences listened to during the speeches that were made bore witness, through their presentation of evidence, to the climate of difficulty and discrimination in which Catholic gynaecologicists and obstetricians now work.

"I began my work at the department of gynaecology and obstetrics in a state-run hospital. I thought that I would have been able to achieve my aims and my wishes by helping people and by helping life, which is given to us by God: this was the motivation that led me to choose gynaecology and obstetrics as a personal vocation. But as soon as I began to work I discovered that to implement Christian principles and to act according to my conscience meant for me to enter into a state of war. I refused to procure abortions and the result was that they forced me not only to leave the hospital where I worked and go to another hospital but also to leave gynaecology because this was the only way I could go on practicing my profession" (Marek Drab, Slovakia).

"In 1998, after two hospitals joined together, I was forced to join four colleagues of the larger hospital in a situation which involved a sharing of all the financial resources. Given that a large proportion of their income came from contraception and surgical sterilisation I refused to join them for obvious moral and ethical reasons. At the level of conscience I could not accept any of that income. I was soon dismissed and I thus lost the privileges of working in a hospital and surgical practice" (André O. Devos, Belgium).

"In Lithuania procured abortion is an important problem for Catholic gynaecologists because gynaecologists have an official right to refuse to carry out abortions only in university hospitals. In the other hospitals these specialists are forced to carry out all operations, including abortions" (Vilune Intaite, Lithuania).

"For a doctor whose conscience is troubled by these implications it is difficult in the United States of America to obtain specialisation in maternal-foetal medicine given the emphasis placed on prenatal diagnosis and its 'therapeutic' correlate, the interruption of pregnancy" (John M. Thorp, Professor of Obstetrics and Gynecology, University of North Carolina at Chapel Hill, USA).

"In Austria the curriculum and the official legal training for obstetrics and gynaecology envisage practical participation in certain kinds of techniques which must be learnt and which are immoral. If a Catholic medical doctor wishes to specialise in obstetrics and gynaecology he or she must face up to a hostile legal and ethical environment. Each medical doctor has to acquire practical experience in pre-conception counselling and prescribe oral contraceptives, the coil, the tying of the fallopian tubes, and other forms of sterilisation, and in addition he or she must procure abortions during the first and second three-month terms as envisaged by the present level of techniques in this areas. If a medical doctor refuses in a permanent sense to follow the practices adopted in his hospital he or she is marginalised" (Tamas Csasky-Pallavicini, Austria).

"In Australia, the training in the sub-specialisation in reproduction requires the person who is specialising to dedicate himself or herself for a certain period of time to artificial fertilisation. Those who raise moral objections to artificial fertilisation are unlikely to pursue this field as a result,

and thereby leave this area and also leave discussion about its issues for the most part to those people whose ethical position is often diametrically opposed to those who respect life from its beginnings" (Adrian Thomas, Australia).

"In Switzerland, abortions should in reality be handled as 'service orders' (in German the word is *Leistungsuftrag*). Thus it is that the studies and the pro-

fessional work of colleagues who do not wish to interrupt pregnancies or take part in procuring abortions is becoming very difficult. Studies are in fact almost impossible if a colleague refuses to be involved with contraception and technically assisted reproduction and operations involving sterilisation" (Rudolf Ehmann, Director of the Department of Obstetrics and Gynaecology, the State Hospital, Stans, Switzerland).

"In 1996 the Council for Graduate Medical Education made training in abortion a requirement for the specialisation schools and for this reason a requirement as well for specialising in obstetrics and gynaecology. Fortunately, following a large number of protests, Congress passed a law which forbids federal, state and local government from rejecting the provision of official approval, licences or financial aid to medical schools or hospitals that refuse teaching in abortion" (John W. Seeds, Professor and President of the Department of Obstetrics and Gynecology of the Virginia Commonwealth University/Medical College of Virginia, USA).

"Catholic gynaecological obstetricians believe that only a few Catholic medical doctors specialise in gynaecological obstetrics today because of a process of self-exclusion from a field which is perceived as being hostile. The medical doctors trained in maternal-foetal medicine feel strong pressure to accept the interruption of pregancy where there are anomalies in the foetus" (T. Murphy Goodwin, Director of the Department of Maternal-Foetal Medicine, the University of Southern California, USA).

The pressure is endless and recently Rachel Masch, the Director of the Department of Reproductive Choice at the New York University Medical Center - Bellevue Hospital, declared that family planning in the future will become a matter of full-time rotation where those engaged in specialisation will spend from four to eight hours every week within the programme, which includes procured abortions.

The conference, in addition to listening to condemnations and reports regarding forms of discrimination, also addressed itself to the legislative situation, and examined the consequences, in the short and long term, that the ideological pressure which can now be breathed in hospitals and universities may have for Catholic women, the presence itself of the Church, and at a more general level for the culture of those societies where gynaecological obstetricians who are discriminated against have to work.

On this subject, it was emphasised that the constant fall in the number of Catholic obstetricians, brought about by the social ostracism to which they are subjected, is giving rise to concern in many spheres. First and foremost, it involves problems for respect for life, which has been debased in the eyes of public opinion by practices which have by now been accepted passively by the medical classes. Secondly, for the moral conduct of Catholic women who are encouraged by medical doctors to adopt choices that involve a removal of a sense of responsibility and which are in line with cultural dynamics and forms of behaviour based upon practical hedonism. The fall in the number of Catholic obstetricians also generates concern as regards pastoral care relating to marriage and the family. Such pastoral care has been deprived of the support of medical doctors who adhere to the Magisterium of the Church and are convinced of the possibilities of offering concrete proposals which are alternative to those proposed by the dominant mentality in the field of choices relating to reproduction. Lastly, there is a negative impact as well on teaching, which is deprived of every kind of critical debate, and on scientific research, which increasingly lacks the input of scientists who are open to lines of inquiry which are not conditioned by ideological pressure and by elements relating to economic convenience.

The conference was enriched by the participation of the heads of all the Ministries of the Holy See concerned with the subjects that were addressed. On the speakers' rostrum the following prelates spoke one after the other: the Secretary of the Congregation for the Doctrine of the Faith, H.E. Msgr. Tarcisio Bertone: the President of the Pontifical Council for the Family, Cardinal Alfonso Lopez Trujillo; the Secretary of the Congregation for Catholic Education, H.E. Msgr. Giuseppe Pittau; the Vice-President of the Pontifical Academy for Life, H.E. Msgr. Elio Sgreccia; and the Ecclesiastical Assistant to the Italian Association of Catholic Medical Doctors, Cardinal Dionigi

Tettamanzi. H.E. Msgr. Javier Lozano Barragán, the President of the Pontifical Council for Health Pastoral Care, the body which together with the FIAMC and the MCI organised this initiative, acted as the general host.

In addition to outlining the moral foundations of conscientious objection, these distinguished ecclesiastical figures discussed in their papers the relationship between the professional activity of gynaecological obstetricians and the pastoral activity of the Church, and presented to those taking part in the conference the opportunities for support and co-operation that they could expect from the institutions of the Holy See.

For those taking part in the conference this was a very important event, of a really universal dimension, which enabled them to strengthen their

moral beliefs and their conviction as to their reasonableness regarding the resistance exercised by them against the pressure of dominant ideologies.

The explosiveness of the subjects addressed during the course of the meeting was easily perceived when, during the audience granted by the Holy Father, these subjects found a very great echo in the press, television, and Internet sites throughout the world. The address of the Holy Father, which was greatly applauded by those present, was fully reported.

The conference, in addition to being an opportunity for information, condemnation, training and encouragement, generated certain important conclusions.

First and foremost, it was agreed that a register would be created of all the university and hospital institutions that are able to offer training programmes that respect the ethical values proposed by the Magisterium of the Church. In parallel fashion, a series of study grants will be set up for people in specialisation courses, in situations involving forms of discrimination, to provide them with training opportunities which respect their moral beliefs.

On this question, those taking part in the conference expressed their desire for a deeper adherence to the proposals of the Magisterium on the part of certain Catholic hospitals and Catholic universities, and complained about a deplorable dichotomy between the Catholic denomination of certain institutions and the real contents of their educational programmes and activity, and professional conduct, to be found within them. The ecclesiastical authorities were requested to engage in suitable controls.

Secondly, it was decided to establish a legal forum of an international character, with local points of reference at a national level, which would be able to study the situations of discrimination that are drawn attention to, and to set in motion, in the relevant judicial contexts legal cases on behalf of gynaecological obstetricians who are discriminated against during their training or their careers, or who are subject to wrongful forms of pressure because of their beliefs.

From a scientific point of view, it was decided to create a highly qualified scientific journal with an international editorial board composed of members of high standing which would publish papers on subjects that are usually neglected by many other such journals (for example natural family planning, the physical and physiological consequences of abortion, studies on the growth of the embryo within a framework of the continued development of the embryo, etc.). Such a journal, however, in order to resist the temptation of succumbing to works of a low quality (although in line with the Magisterium of the Church) would be endowed with a rigid and final system of critical assessment to ensure the acceptance for publication only of high quality research.

Given the advances in information technology and data communication, those taking part in the conference decided to create a preparatory committee which would be able to develop (using suitable advice and help where necessary) systems of distance learning and computer-based libraries on the issues and subjects of reproduction, thereby encouraging the circulation of texts and audiovisual material.

Lastly, the participants called for the periodic holding of similar meetings so that they could engage in a shared examination of the developments in scientific research and of specific practical questions. They decided to meet again in Rome at the end of October 2002.

At the end of the conference, MaterCare International communicated that it had asked the FIAMC to be recognised as an affiliated body having the specialised ability to make cultural and practical contributions to the field of gynaecological obstetrics.

The climate of exchange, of friendship, and of brotherhood felt by all during this conference should be observed in a special way, and such a climate allows us to hope that there will be further positive developments in the future.

Dr. GIAN LUIGI GIGLI,
President of the FIAMC

Protecting Human Life in a Changing World: the Responsibility of Catholic Obstetricians

The Catholic Church has always been for life and has always defended it in all circumstances. This is something that is obvious given that the Church is the Church of Christ, who came into the world with a very specific mission: “I have come so that they may have life, and have it more abundantly” (Jn 10:10). Certainly, Christ died for our sins, but he rose again for our salvation (Rom 4:25). The Church carries on the mission of Christ and in so doing bears witness to the resurrection, to the fullness of life.

We know with certainty that we are all part of the Church and that, therefore, we must all bear strong and clear witness to the fact that Christ rose again and is the Lord of life. The world is not intended for death but for life, for the fullness of life. And if there is someone

who is directly expected to bear this witness it is specifically the health care professional, because, in being a health care professional, he is also a minister of life. His mission is to bear witness to the resurrection of Jesus Christ our Lord. His learning and expertise, his technical skills, and his ability are all directed towards giving life, and thus if a health care professional turns himself into a professional of death this is in opposition to sense, it is a contradiction. This is true for hospitals as a whole, and above all else for medical doctors, paramedics, nurses, pharmacists, voluntary workers, hospital managers, certainly for those priests who dedicate themselves to the health and health care sector, and, lastly, for all the personnel who in some way are involved in the promotion of health.

My paper is organised into three parts: threats to life; the responsibility of health professionals; and some guidelines for action.

I. Threats to Life

1. Their Description in 'Evangelium Vitae'

God did not create death – He created life. But by the work of the Evil One, death was placed in the world. Not only was it placed, but it is continually being placed. The Evil One did this at the beginning of human history, he has done it during the course of that history, he has done it at every stage of the life of mankind, and he continues to do so today. He has done this in different ways and today new threats have arrived. Wars, diseases, and misfortunes of every kind have always existed and continue to emerge according to the vicissitudes of history. But, in a specific sense, what are the threats to life today which require the provision of special protection by health care professionals? The Holy Father John Paul II speaks about these threats in his encyclical letter *Evangelium Vitae*. He argues that 'some threats come from nature itself, but they are made worse by the culpable indifference and negligence of those who could in some cases remedy them. Others are the result of situations of violence, hatred and conflicting interests, which lead people to attack others through murder, war, slaughter and genocide'. He also speaks to us about poverty, about wars, about the upsetting of the world's ecological balance, of drug abuse and of the bad practice of sexuality: 'it is impossible', he goes on, 'to catalogue completely the vast array of threats to human life, so many are the forms, whether explicit or hidden, in which they appear today'.[1] The Pope says that we are dealing here with 'a veritable structure of sin. This reality is characterised by the emergence of a culture which denies solidarity and in many cases takes the form of a veritable 'culture of death''.[2] The value of life is today suffering from a kind of 'eclipse'.[3] Anti-conception, abortion, prenatal diagnosis with a view to eugenics, death for the terminally ill and euthanasia, are upheld; fear is felt because the population increase is seen as being a very great danger; no meaning at all is to be found in suffering; sterilisation is imposed; and the social means of communication are placed at the disposal of these policies.[4]

2. Their Description at the World Conferences on Population

As evidence of what I have just said, and after seeing how these questions and issues have existed until our times, let us now see what the recent world conferences on health care have said. At these conferences an attempt has been made to go to the heart of the matter, to the point of reaching the origins of life so as then to assault it. Here some of the most significant aspects of what has been done can be drawn attention to, which are as follows.

Let us begin with the *Conference of Cairo* (UNO/Cairo, 1994). During its deliberations it was argued that sexual reproduction was dangerous for the world because, it was said, it fostered population increase, whereas the world does not have sufficient resources to provide for, and to feed, the excess in population. A sexual revolution, therefore, was spoken about in the sense that sexual rights should have a legal status, without these rights necessarily implying human reproduction. The question of abortion was also talked about, where abortion was seen as a right held by women. It was said that it was necessary to broaden the traditional concept of the family. The point was reached of saying that all those who live under the same roof constitute a family, defending thereby *de facto* unions, unions between homosexuals, and every other form of living together. The concept of the family which has at its base marriage between the two sexes, and which is one and indissoluble, is increasingly being distanced from agreed views at a world level. Family planning was also spoken about, not in the sense of an authentic regulating of the family but rather of the elimination of fertility, and was especially directed towards countries of the third world whose population increase is intensely feared by rich countries.

At the *Conference of Peking* (UNO/Peking, 1999) the sexual rights of girls and women were spoken about with an underlying anti-conception mentality. Along these lines, even the end of violence and discrimination against women was proclaimed. It was said that the rights of women are human rights – which is obviously the case – and that this involved the proclaiming of the right to engage in an abortion as a human right. All this, in a more or less open way, was argued when reference was made to the right of adolescent girls to information about sexual and reproductive health, and to use medical services without interference from their parents.

At the meeting of the United Nations Organisation known as *Cairo+5* (1999), five years after the Conference of Cairo, a proposal was advanced on the lawfulness of the 'morning after pill' (an evident abortion-inducing pharmaceutical prod-

uct), so-called emergency contraception, and unsafe abortion. On that occasion the right to 'privacy' was presented as something different: the right of adolescents to privacy and to sexual education from elementary school was talked about. And all this in the sense of the free practice of sexuality, obviously not within the context of procreation and even less of the creation of a family. Once again reference was made to abortion as a human right and of the training of health care personnel in the practice, in the best way possible, of abortion, without taking into account the dictates of their conscience.

The last encounter of the international conferences concerned with life was *Peking+5* (Peking+5, 2000), held five years after the Conference of Peking. While it was being organised, the Western countries, Europe and the United States of America included, together with the G77 group of dissidents, launched a serious attack and fought against the family and in favour of abortion. Their formula was: 'free and total access to all health services', including thereby abortion, and they were not prepared to accept any clause protecting the right to conscientious objection for medical, nursing, or obstetrics personnel, with the consequence that such people would be obliged to carry out an abortion. Another formula advanced was that of 'sexual orientation' and the 'need' to modify the role and the identity of the stereotypes of men and women. There was an attack on the 'traditional roles attributed to a single gender... which oblige women to take on all the weight of family responsibilities'. The non-recognition of 'sexual orientation' (including homosexuality) was seen as a violation of human rights. In this way an attempt was made to proclaim sexual rights as human rights, opening up the road to the right to pornography, the right to prostitution, the right to abortion and the right to sexual perversion. At the final vote all these proposals were not approved.[5]

3. The Present-Day Panorama

There can be no doubt that the present-day panorama of threats to life is distressing, that there exists a totally Malthusian mentality, that there is a wish to replace the family based upon marriage with various types of union including that of homosexuals, that sexual life is seen as banal, that a child is received as the outcome of a selfish desire. There is no legal protection of the embryo, abortion is being legalised, life is valued only from the point of view of its productivity, throughout the world there are situations of hunger, illness and misery, war and genocide, everywhere embryos are used for commercial, experimental or therapeutic ends, prenatal eugenics are practiced, attempts to engage in human cloning are looming on the horizon, the phrase 'pre-embryo' has been invented in order to bestow legitimacy on abortion, there is an increase in gene banks, frozen embryos, artificial fertilisation, the use of human stem cells, the use of embryo and foetus tissues, and research into the human genome is prospering with in mind its manipulation in line with eugenics based on abortion.[6]

To what has been listed above we can add the pandemic of HIV-AIDS, the increase in malaria and tuberculosis, in respiratory diseases, in hypertension, in diabetes, in cancer, in infectious diseases, in tobacco use, in the death of mothers at childbirth, in ebola, in alcoholism, in traumas of every kind, etc.

As will be obvious, this is not a general survey of health care in the world. We must not fall into a black pessimism, because, at the same time, we find ourselves faced with wonderful progress in the world of medicine, and life-expectancy has grown in most of the peoples of the world. The realities that we have described hitherto refer to some of the most significant threats to life which exist in the world, which, precisely because of their severity, make the question which we pose to health care professionals – so that they may provide a response – ring out strongly.

II. The Response of Health Care Professionals

1. The Causes

In order to outline a response we must examine the causes behind this situation. The Holy Father does this in a detailed way in the encyclical which has already been referred to when he maintains that the threats to life are due above all else to a way of thinking which holds that a right belongs to someone who has at the least an incipient autonomy and that freedom is absolute autonomy, and to thinking with alleged altruism and pity in relation to possible deformations of a new life within the foetus; to a way of thinking which holds that the right to life is something which is exclusively the concern of parliamentary decisions; to the fact that an eclipse of the meaning of God and thus of man has taken place and that life is catalogued as something, when subjected to technological treatment, which can be manipulated absolutely; to the view that nature must be seen not as something which is sacred and which comes from the hands of God, but should be seen as a kind of mine, of building site, of matter to be manipulated totally according to human will; to the belief in the body and sex

as mere tools for the affirmation of the self and the selfish satisfaction of one's own desires and instincts; and to a deformation of the moral conscience of society, moulded by 'men who by their wickedness suppress the truth' (Rom 1:18).

2. Inner Responsibility

If we reflect on this set of causes we see that the response must spring from the innermost part of man, so that, in discovering himself, he also discovers God, who is the source of life.

In fact, responsibility is the capacity to respond. And this capacity is centred in man himself. Man places himself in front of his own fulfilment and

begins to build that fulfilment. Responsibility consists of this capacity to build oneself. Freedom enters the picture as the possibility to choose what is most useful in this construction. When we place ourselves on the plane of health care professionals we realise that the question raised by the threats to health care raises another which is even more profound – that regarding one's own personality as a health professional. This is a question which requires us to raise our gaze towards our own purpose and our own model which for the Christian health care professional are nothing else than the risen Christ.

The Pope says the following in the encyclical which has already been cited: 'Israel comes to learn that whenever its existence is threatened it need turn only to God with renewed trust in order to find in Him effective help... Today, too, by looking upon the one who was pierced, every person whose life is threatened encounters the sure hope of finding freedom and redemption'.[8]

3. The Effectiveness of the Resurrection

For the professional of health, even more, this purpose and this model are not something external which acts through imitation or through a merely volitional impulse with relation to the perceived purpose, but, instead, a real engine of effectiveness. The risen Christ is he who encourages us to provide a response and it is he himself who offers the answer. In the face of the importance of the problems encountered there is no place for discouragement and no place for us, when measuring our own strengths, to find that they are not up to the task in hand, but rather there is a place for the humble and total acceptance of the capacity of his personality together with the whole of contemporary learning and technology, at the service of the vivifying force that realises, in concrete terms, life – that is to say Christ who died and rose again. In this consists the redemption that Christ offers us in the concrete situations of the world we live in. We can appreciate in a clear way in these circumstances the need for a redemption which really rises above all our strengths but which achieves the marvel of making health sacred, using our scarce but indispensable capacities.

4. The Pope to the Pontifical Academy for Life

Pope John Paul II spoke again on this subject when he recently addressed the members of the Pontifical Academy for Life (16 March 2001), saying that we should offer solid and enlightening contents to the culture of life so as to regenerate continuously the inner tissue of contemporary culture. Human life must be presented as a gift from God and man must be presented as his free and responsible co-worker, giving emphasis to the dignity of the human person and to the family as a community of love and life. Life is persecuted but it will manage to win – this is our sure hope because on the side of life there are freedom, good, joy, real progress, and God. Jesus Christ gave his life to defeat death and to associate man with his resurrection. The Gospel of life is something which is concrete and personal because it means the preaching of the very person of Jesus, who tells us: "I am the way, the truth, and the life" (Jn 4:6).

The Pope goes on and says that all of this resides in the innermost part of the person; it is not something which we know solely through Revelation. It flows forth from the very reason of the creation, of the dignity of the human person, of the dignity of the body as a human subject in a unitary conception. We should increase the dialogue between faith and reason, joining together within the human person dignity and sacredness, freedom and responsibility, giving emphasis to the stewardship of the environment, the right to life from its conception until death, the family, and the primary design of God for the reproduction of life. Great challenges are taking place within the context of present-day progress and the

secularisation of society. Both dialogue and listening are urgent. 'Without a culture which maintains solid the right to life and promotes the fundamental values of every person, one cannot have a healthy society or the guarantee of peace and justice'.[9]

III. Guidelines for Action

1. Prayer

What are the guidelines for action to implement this great responsibility in relation to life? In the first place, says the Pope, 'a great prayer for life is urgently needed, a prayer which will rise up throughout the world. Through special initiatives and daily prayer, may an impassioned plea rise to God, the Creator and lover of life, from every Christian community, from every group and association, from every family and from the heart of every believer'.[10]

2. The Direction

We must also have a clear Christian idea of life, understood as a mission, a mystery, and communion. The point of departure for building a culture of life is the recognition that life is a mission. Christ said: "I have come so that they may have life, and have it in abundance" (Jn 10:10) and the life that he has given us is the life that he has in the Father and that the Father has in him (Jn 6:57). The life of God, the life of the Most Holy Trinity, cannot be annihilated by death. The mission of Christ is that of offering us this life in the Most Holy Trinity, and his mission cannot fail. For this reason, this life is a life which is the fruit of communion and, even more, is it is the same communion as that of the Father with the Son in the Holy Spirit (2 Cor 13:13). Life cannot be separated from communion; indeed, the highest life of man is that which is received in baptism, divine life, and this life is received in communion with the whole of the Church. In the same way, the reproduction of this life is given only in the highest human solidarity and communion, that is to say marriage, which is baptismal life doubled in matrimonial love, in the full and indissoluble love of a man and a woman.

3. Bioethics

A profound practical form for the protection of life by health care professionals is to know and to apply bioethics in a correct way, especially with regard to the complicated questions and issues connected with the human genome. When we speak about the correct application of bioethics we refer to authentic bioethics which start with previously enunciated principles regarding life.

Indeed, the fundamental problem of bioethics today, their fundamental basic problem, is the problem of their principles. Bioethics is *the scientific study of human behaviour in the context of the sciences of life and health, in conformity with values and moral principles*. The question immediately arises: which values? Which moral principles? It is not difficult to find an answer in the Catholic world – they are the values referred to above. But bioethics are developing rapidly in a forceful way in the non-Catholic world, especially in spheres of a Protestant matrix, and in this field neither the values nor the moral principles are clear. This absence is also evident in ethical positivism, in which it is not possible to speak about such principles in a rational sense.

In fact, in traditional Christian thought the principles are the law of God, the commandments of the Law of God based upon the natural law itself, which were exalted in the life of Christ and which have just been discussed in this paper. But in Protestant thought natural law does not appear as something acceptable because it is thought that nature is simply spoiled, that it is bad, and thus cannot be fixed as a norm upon which to act. In depriving nature of the authority to be a source of morality, we must look for other external and often very arbitrary forms which do not have their foundation in nature.

As has already been observed in this paper, for Christian moral thought, including Revelation which for the moment will be left to one side, ethics are a consequence of metaphysics: if nature has a purpose, then it is rooted in an anthropology in which man is presented as a being endowed with purpose and as such on a journey towards that goal. Ethics describe to us this journeying towards the eternal. But if we deny nature and leave metaphysics out of the picture, there is no longer a purpose and there is not even a metaphysical anthropology. And, as a result, there are no real ethics.

Bioethics are seen in this way from two standpoints. One standpoint accepts metaphysical thought and Revelation, anthropology and ethics based upon metaphysics and Revelation; the other does not accept this thought and tries to formulate other bases, or even no basis at all. The first standpoint is called 'personalism' and the second 'positivist bioethics'. An explanation of the principles of ethical personalism will in an essential way help the professionals of health to protect life against the threats which hang over it.

4. The Principles of Personalism in Bioethics

1. The human person is created by God, from God he comes and to him he is directed as his first and final cause. The human person is capable of reflection, and in himself he is an end and can never been seen as a means. He is the synthesis of the universe and he that gives reason to everything that exists. Here anthropology and ethics find their foundation.

2. As a result, human life is sacred because it comes from God. For the same reason, the dignity of the human person is inviolable.

3. The human person has his own freedom and his own responsibility which he must exercise to fulfil himself. There cannot be freedom without responsibility, and this means re-

specting the freedom of other people.

4. Everything is above the interests of an individual and at times it is necessary to abandon individual interests out of respect for the whole.

5. The human person exists in solidarity and must aim for the common good.

6. In this context the three principles of autonomy, doing good, and justice, which are adopted by positivist bioethics, are accepted and justified. The principle of *autonomy* means the freedom of the moral agent, which in turn is said to indicate that an action is good if it respects the freedom of the moral agent and of other people. The principle of *doing good* means that good should always be done and evil should always be avoided. The principle of *justice* means that every person should be given what is due to him.

7. The person is the image of God, part of the Body of Christ, and a citizen of the people of God.

8. Suffering, if assumed in union with the suffering of Christ, is something positive and is a source of salvation.

9. Life is inviolable from its conception to its natural end.

10. Human life must have its origin only in marriage.

11. Human life must have its origin in marriage, in the conjugal act.

12. Sciences are at the service of human life and not vice versa.

13. What has been outlined above must be expressed in the civil laws of States.[11]

5. Application to Specific Cases

More than continuing now with a list of specific cases in the sphere of biogenetics, what has been outlined above may be sufficient as a response to the specific problems, which without doubt will present themselves to today's health care professionals, so that they can protect life in the face of anti-conception, abortion, the use of stem cells, banks of genetic material, in vitro fertilisation, human cloning, the renting of wombs, the production of embryos, the freezing of embryos, the use of foetal tissues, eugenics, arbitrary sexual freedom, homosexuality, sexual information without suitable training, divorce, euthanasia, etc.

We have sought to clarify the panorama of life faced with the culture of death and it is the responsibility of every health care professional to bring this light into the daily situations which he encounters in order to always protect life.

Let us conclude as the Pope does in his encyclical when he observes that the model of life of the new culture is the Virgin Mary in relation to the birth of the Son of God, as she appears in the twelfth chapter of the Apocalypse: the woman is about to give birth and the dragon is awaiting the birth of the child in order to devour it. Two wings are given to the woman so that she can take refuge in a safe place in the desert where she will give birth and the dragon will no longer be able to do anything against her and her offspring. Life is protected against the threats of death. The triumph of life is the resurrection. Mary is the source of life, she is our model and our safety in forging the new culture of life.[12]

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

Notes

[1] JOHN PAUL II, the encyclical letter *Evangelium Vitae*, 25 March 1995, 9-11.
[2] *EV* 1, 12.
[3] *EV* 1, 11.
[4] *EV* 1, 13-17.
[5] R. MARTINO, 'Cinque anni dopo II Cairo e Pechino', in Pontificio Consiglio della Famiglia, *I figli, famiglia e società nel nuovo millennio* (Vatican City, 2001), pp. 172-180.
[6] *J.E. I. Mart_ez*, 'Presentazione del Congresso Europeo dei Movimenti per la Vita', in Pontificio Consiglio della Famiglia, *I figli, famiglia e socità nel nuovo millennio* (Vatican City, 2001), pp. 181-188.
[7] *EV* 1, 19-23.
[8] *EV* 1, 31; 2, 50.
[9] JOHN PAUL II, 'Discorso all Pontificia Academia per la Vita', *L'Osservatore Romano*, weekly Italian edition (11), 16 March 2001, 2.
[10] *EV* 4, 100.
[11] L. CICCONE, 'Storia e problematiche oggi', and A. Spagnolo, 'Bioetica Fondamenti', in Camillianum, *Dizionario di Teologia Pastorale Sanitaria* (Camilliane, 1997), pp. 130-154.
[12] *EV*, 103-104.

A Question of Conscience

It was quite a surprise, back in 1973, to be informed by an eminent professor of obstetrics and gynaecology, after an interview for an appointment as a senior registrar, that as a Roman Catholic specialist "there is no place for you to practice within the National Health Service unless you are prepared to change your views or to re-specialise in another field". One had always, quite naively is seems, thought that the British "system" was based on fair play and above all, respect for an individual's right to conscientious objection, for example in the time of war. It soon became obvious that in order to stay in the specialities in the United Kingdom, I would have had to compromise a conscientiously held abhorrence to the direct taking of human life. I refused and as a consequence became unemployed with a wife and three children and had to leave country, home and family in order to practise my chosen speciality in full freedom.

In 1976 I published a paper in the *British Medical Journal* about my experience and warned that the practice of ob-

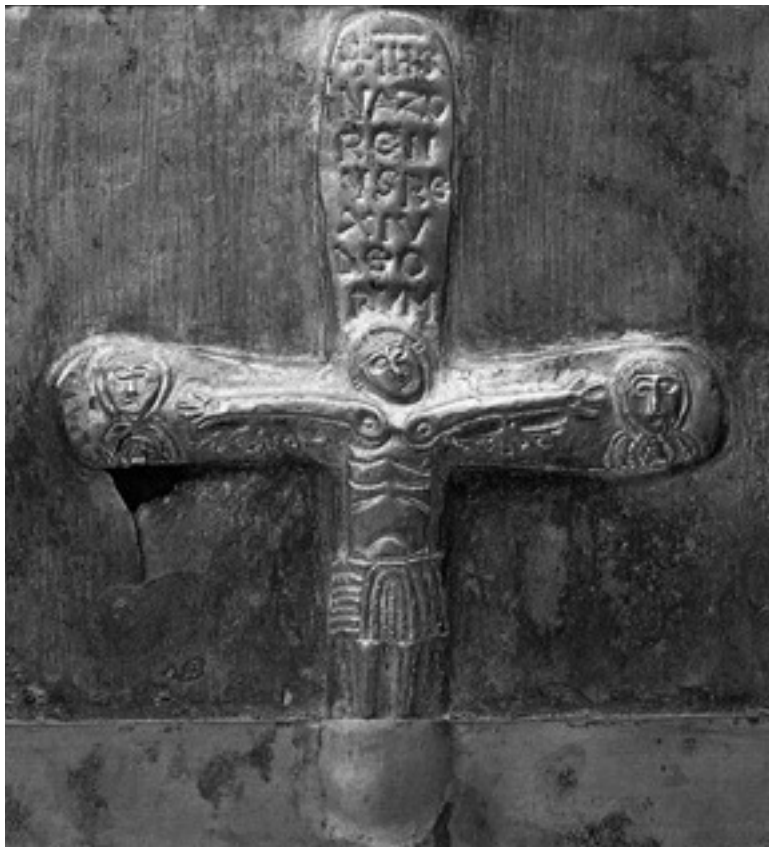
stetrics in the UK would suffer, as the main consequence of the denial of conscientious objection to performing abortion there would develop what I called a "sameness of practice" which would stifle further thought and progress. This prophecy concerning obstetrics in the UK has come to pass and discrimination against catholic and other pro-life doctors continues in the UK and other parts of the world.

It was early in my medical student career that I decided to specialise in ob/gyn. The appeal was that these specialities required skills in medicine, surgery and special skills related to obstetrics. It became clear to me that obstetricians and midwives have a unique and privileged vocation in the service to life as they are assistants to the co-creators of new life. We are specialists in motherhood.

When I began obstetric residency training back in 1968 residents were told that obstetricians had one objective, which was to provide the best of care that was humanly possible, to ensure that all pregnancies should result in a live healthy mother, and a live healthy baby. It was made clear that at the beginning of every pregnancy we had two patients to look after as the following statement taken from the of Williams Obstetrics (sixteenth edition) states;

'Happily we live and work in an era in which the foetus is established as our second patient with many rights and privileges comparable to those previously achieved on the afterbirth.'

However, back in the early 70s, the general public and even Church leadership did not anticipate the dark changes that were about to occur that would turn maternal health care upside down, and cause many obstetricians to make serious decisions about practice and living which had profound effects on their careers. As I finished training, the oral contraceptive was being introduced, and I remember attending one of the first demonstrations of the intra-uterine device. At the same time legislation permitting abortion was passed in the UK. As residents we were exposed to a one-sided, ill-informed and prejudice opinion by those determined to change how we thought and practised. Significantly in later editions of Williams that reference to the foetus as a second patient was dropped A subtle gradual process began to bring about a fundamental change in the way obstetricians considered themselves. The difference between obstetrics (maternal health care) and gynaecology (women's health care) became blurred. Reference to motherhood was dropped and we now find ourselves to be simply women's health specialists.



At about the same time the Encyclical *Humanae Vitae* was promulgated. I remember reading it and my first reaction was to wonder if it had any relevance to my practice. I started to rationalise that there was a difference between contraception and abortion – I could accept the former but not the latter. The decision was quite simple and most of my friends and colleagues accepted that idea too. There was no one around to turn to for advice or guidance. However, for some reason, most likely the inspiration of the Holy Spirit, I reread and thought about it and began to understand its importance to marriage, human life and family.

Abortion and contraception soon became the basis of the health care of mothers. In spite of knowing so much about the unborn child obstetricians connived in devaluing the human being in the womb, thus making it so much easier to destroy. Society accepted abortion as an easy solution for social and economic problems and ob/gyns have allowed their professional skills to be used for that purpose. Many of our colleagues now destroy more babies than they deliver babies. Little effort is made to reduce the number of abortions. It defies belief that William Jefferson Clinton, the President of the United States of America, should have twice vetoed a bill which would have outlawed the obscenity of partial birth abortion. The world has accepted the culture of death at the cost of unborn children and a once noble profession. Pope John Paul has commented;

'The medical profession today is suffering fundamentally

from an identity crisis; the grave danger exists that when this profession is called upon to suppress conceived life; where it is used to eliminate the dying; where it allows itself to be led to intervene against the plan of the Creator and the life of the family or to be taken by the temptation to manipulate human life; and when it loses sight of its authentic direction of purpose toward the person who is most unfortunate and most sick, it loses its ethos, it becomessick in its turn, it loses and obscures its own dignity and moral autonomy.'

For the Catholic in training or in practice this has had profound ethical, moral and practical significance. No other branch of medicine has been so affected by these developments. It has simply not been appreciated that obstetricians of my generation had, from the very beginning of these developments, to take a fundamental stand in defence of human life. This caused them, and their families, considerable pain as they found their careers in ruins. Many were forced out of the specialty; others sadly compromised in order to survive. In some countries many are forced to participate in abortion or contraception programmes and sadly many decide to compromise and separate what they do from what they believe.

In very personal ways Catholics specialists and their families have been subjected to a sort of professional totalitarianism. The Catholic ob/gyns who remained faithful to the Magisterial teaching were and are professionally and socially ostracised. Sadly even in catholic hospitals they are considered an 'embarrassment because of their public stand and are considered as ultra conservatives, professionally outdated, and even possibly negligent and are subjected to the displeasure of the profession. Generally there is a recruitment crisis as few students are electing to specialise in ob/gyn basically for three reasons; the lifestyle is quite hard; there is fear of litigation especially in North America and Europe and most doctors really do not want to get involved in abortion – it is regarded as unpleasant work. It is not surprising that very few Catholics are entering ob/gyn, thus the Catholic ob/gyn is now in danger of going the same way as the dinosaur, having been frozen out by the abortion/contraceptive asteroid. This should be a source of grave concern to the Church, to pro-life organisations and to all people of good will.

This raises important questions; what effect does all of this have on mothers and women? Where will they obtain opinions and treatment for their health problems which are in accordance with their moral convictions? Are women being unduly influenced by doctors or nurses who do not understand or care about religious convictions? In other words who in the future will make any practical reality of the Church's teaching concerning maternal health care?

In 1995 a small international group of Catholic ob/gyns/midwives met at the Life Health Centre in Liverpool England. All had have been asking themselves the same question; if we don't do something WHO WILL? This stubborn few believed that if they held to their ethical and moral principles, they could be effective in caring for mothers and their unborn babies and that there are mothers around the world who still want the sort of care that they can provide.

Pope John Paul II in his Encyclical *Evangelium Vitae* also issued an urgent appeal to all, but in a special way to Catholic health professionals, to do something extra for life;

'To the people of life for life', 'to offer this world of ours new signs of hope, and work to ensure that a new culture of human life will be affirmed, for the building of an authentic civilisation of truth and love' (E.V. No 6).

'To all health care personnel who have a unique responsibility to be guardians and servants of human life'. (E.V. 89).

'A specific contribution must come from Catholic universities, Centres, Institutes and Committees of Bioethics and places of scientific and technological research'. (E.V. 98).

That group established MaterCare International (MCI) which has adopted a preferential option for mothers and their unborn children. The intention was not to develop a talking shop, but an organisation that would breath life back into the care of mothers through new initiatives of service, training, research, and advocacy in accordance with the teaching of the Encyclical, *Evangelium Vitae*. MCI intends to place itself;

'... at the service of a new culture of life offering serious and well documented contributions, capable of commanding general respect and interest by reason of merit'. (E.V. 98)

MCI is developing a revolutionary structure for the 21st century i.e. no large buildings with large heating bills but a small international central agency and national groups that support flexible reference centres, distributed throughout the world, all linked together through modern communication technologies. MaterCare is legally established in Canada, Ireland, the UK (and therefore the European Union) and is in the process in the USA, Australia and Ghana. Each national group has an interdisciplinary board of directors. With these national structures MCI can access funding from private and government sources to carry out projects and recruit colleagues to carry out the work.

The international centre is located in St John's Newfoundland, Canada provides the specialist support for national centres. The centre presently consists of an obstetrician, a professor of nursing, a secretary, a public education co-ordinator and a volunteer board. In the future we hope to have a staff that will reflect the unique, international, interdisciplinary, diverse vocational character and experience of our Church, and will include an administrator, medical and nursing directors, theologian/ethicist, health educator, communications expert, and support staff. It is the board of MaterCare International which is made up of two members from each national MaterCare groups that deter-

mines policy and chooses projects. The international board meets quarterly by international telephone conference calls which is quite cheap. In the future it aims to set up a method for international teleconferencing using the internet, which is free. National reference centres will be established, where there is interest and according to local needs. The first one will be in Ghana, West Africa. These reference centres will be the initiators of local activities and will gather information, implement services and educational programmes, conduct research and also provide the group of specialists.

MCI has shown, despite scepticism and not without considerable labour pains, that it can be relevant. In 1998 MCI developed a West African Maternal Health and Obstetric Fistula Project, the first phase of which is now underway in Ghana and consists of prevention, research and advocacy programmes. The prevention programmes are designed to reduce maternal mortality and morbidity in rural areas by improving the care given to mothers by traditional birth attendants (TBAs) in villages by using a pictorial antenatal card, by training nurse/midwives in maternity centres to use the labour partograph, a visual means of monitoring the progress of labour and by an emergency obstetric transport system with blood transfusion capability to transport mothers with complications to the district hospital safely.

A research programme has been completed which has evaluated a new oral, effective and inexpensive method of managing life threatening postpartum haemorrhage, which could be used safely by TBAs when medical aid is not available.

An advocacy programme is also being developed to bring to international attention the tragedy of maternal mortality and the suffering of mothers with obstetric fistulae

MCI is also developing a 60-bed birth trauma centre to provide treatment and a rehabilitation centre for mothers with obstetric fistula, which will also have a special interest in training nurses and doctors in the management of these patients. All of these projects are being carried out in partnership with the Catholic Conference of the Bishops of Ghana. MCI is also developing an obstetric fistula teaching CD which will be made available free of charge and which also will be available on MCI's website.

In 1999 Dr GigIi and I visited Albania and to cut a long story short we organised a rotation of obstetricians to an Austrian military field hospital to provide care for about 20,000 refugees. The reason that it did not get off the ground was that the bombing of Kosovo stopped and the refugees went home. Last year I made three visits with Adrian Thomas and then Gian Luigi Gigli to East Timor to look at the problems facing mothers. MCII with the help of FIAMC is in the process of developing a programme to provide essential obstetrical care where as of now there is no obstetricians for a population of 700,000. What we did discover however form these experiences is that there is no international organisation that exists to provide mothers with specialist care. Neither the ICRC nor MSF itself. Emergency services are also being developed in East Timor.

MCI has had requests to find an obstetrician/administrator for a Catholic hospital in Bethlehem and the Archbishop of Freetown Sierra Leone has asked for help in developing maternal health services.

MCI is particularly concerned about the future of ob/gyn and the training. Three years ago we tried to set up an international meeting to discuss the training of future specialists but without success. In our opinion there still remains throughout the world academic and hospital departments of obstetrics and gynaecology which could offer quality residency courses and electives using the new information technologies and distance learning. All we have to do is to organise ourselves.

Conclusion

As we approach the twenty-first century, millions of mothers throughout the developing world are dying from childbirth complications frequent during the middle ages. In the developed world millions of unborn children are being destroyed by the medical profession with surgical procedures which were common in the dark ages of human ignorance.

Obstetricians and midwives share a unique and privileged vocation in the service to life. A group of Catholic health professionals has taken a preferential option to care for mothers and has created an international organisation which will be different to any other professional organisation as it will provide mothers with the best of obstetrical care which is firmly based on medical excellence, life and hope. We know WHAT must be done and for WHOM; this proposal is one way of answering the question HOW are we as Catholic health professional are going to do it.

Prof. ROBERT L. WALLEY,
Frcsc, Frcog, Mph (Harvard)
Professor of Obstetrics and Gynaecology Memorial University of Newfoundland,
Executive Director
Matercare International

The Importance of the Catholic Obstetrician-Gynaecologist for the Presence of the Church in the World of Health and Health Care

The pastoral care of the Church has always taken advantage of the contribution of laymen, and this was even more the case after Vatican Council II. Today the contribution of laymen to such pastoral care is even more necessary given the decrease of priestly and religious vocations.

In particular, the pastoral care of the Church in the world of health and health care needs laymen in order to accomplish Christ's mandate: to preach the Gospel and to heal the sick. Healing the sick is not something to be added as an afterthought, but it is rather an almost integral part of evangelisation, it is that which makes it believable. Jesus himself characterised his message as 'healing the sick'.

It is for this reason that down the centuries the Church has developed deaconries, hostels for pilgrims, monastic infirmaries, and religious orders devoted to providing the assistance to the sick. It is for this reason that the Church invented the very concept of the 'hospital' and largely contributed to developing those features we nowadays have before us. Even when the modern States, after the French Revolution, began to be interested in health, in order to keep high the ideal of health care the Church favoured the founding of Catholic health care institutions all over the world: from the prestigious great hospitals and faculties of medicine of Catholic universities to the dispensaries in the missionary countries. Today, the Church is still the major single non-governmental health care provider in the world.

This enormous effort was not, and is not, aimed only at making up for a lack of concern on the part of governments in relation to some forms of poverty and marginalisation; the effort was, and is, a witness to the fact that attention directed to the human person is not true unless the whole of man is involved, even when he is frail, weak, and reduced, and all men are involved, even when they have been abandoned and their social weight or their importance in the society of productivity and commodities are no longer significant.

It is for this reason that we can say with pride that the effort of the Church in the world of health and health care has greatly contributed to the development of human civilisation, favouring all over the world the growth of a culture of mercy and of compassion, of rights and of respect for man in all situations of life and in all stages of his existence.

But the presence of the Church in the world of health and health care was, and is, moved by the awareness that it is precisely when man expresses the need to be healthy that he is led to question himself about the fundamental questions of life: the meaning of birth, of suffering, of death. The Church is aware that a correct answer to these questions can also influence the answer to other questions on which the religious consciousness of man is founded. Who am I? Where am I going? What meaning does my life have? The need to regain health can, that is to say, lead to asking for salvation *(salus).*

It is for these reasons that, even in non-Catholic hospitals the Church has always favoured the presence of chaplains, of sisters belonging to nursing Orders, of doctors and nurses with Catholic training and faith, and of volunteers inspired by the model of the Good Samaritan.

In this sense, the specialist doctor in obstetrics-gynaecology and the obstetric nurse share the responsibility of every Catholic health worker for the pastoral care in health of the Church.

Today, however, their role has become much more important and their responsibility is greater. Up to a few decades ago, in fact, the morals of doctors and Catholic morality were rarely in contrast and the Catholic doctor had no difficulties in making available to his patients all that medical science offered, without, as a result, suffering from conflicts of conscience. It is true that there have always existed doctors and midwives who have performed abortions, but they did so outside the common ethical codes recognised by the profession and in a hidden manner because they would have been condemned. Until the beginning of the 1970s, textbooks of forensic medicine listed only four types of abortion: spontaneous, therapeutic (to save the mother's life), eugenic and criminal abortion. In relation to the last two types professional condemnation was extremely clear.

Things have changed deeply over past decades. The availability of methods of pharmacological contraception, the feminist movement, the introduction of abortion into a large number of sets of legislation, the growing possibilities offered by genetics to discover illnesses before birth, the development of techniques of in vitro fertilisation, the consequent production of embryos with the objective of curing sterility, their availability to scientific research, the discovery of the potential of embryonic cells for the development of useful tissues for transplantation for the cure of degenerative illnesses, and the hypothesis of total or partial cloning, which has already been carried out with animals, have all radically changed the scene.

Pregnancy and childbirth are no longer seen as acts which are, most of the time, physiological in character; they are, instead, often experienced as a disgrace and an illness which the doctor must take it upon himself to cure. A child is no longer seen as a gift, but as an object of desire, to be made only if one wants one, when one wants, and to be accepted only if the gift is well packaged and not damaged.

Medicine no longer has as its objective the defence of life - it is more worried about the quality of life. International organisations have given up the fight to ensure that fundamental rights of health care are upheld for all populations and social strata; they are only concerned about reducing the request for such rights, thereby favouring a fall in the birth rate all over the world.

The ambiguous term 'reproductive health' has been created, behind which, together with the prevention and control of gynaecological illnesses, contraception, abortion, sterilisation, and a fall in the birth rate are propagated, offered to and imposed on governments and health workers, while we continue to overlook maternal mortality, which is still too high in some developing countries in the world and in some disadvantaged social strata in developed countries.

The Catholic obstetrician-gynaecologist and the midwife are naturally in the middle of these tensions and changes. The Catholic obstetrician-gynaecologist has always been the doctor of women, and he or she feels the pressure of a social ideology that would like to make him or her an instrument to by which to achieve reproductive health, understood in the terms mentioned above, in a safe and efficient way, and by which to develop the new technologies of reproduction in an unhindered way. While this pressure is being applied to his or her conscience, he or she also feels the responsibility of being the doctor of the youngest and weakest among men, the defender of those who have no voice, who express no vote, who have no economic or social weight.

In some situations the conflict between social pressure and the responsibilities of conscience can become unbearable. It can lead, on the one hand, to an abandonment of the profession, so as not to subject the conscience to what is unacceptable, or, on the other hand, to compromise and conformity, so as not to have to abandon the profession.

This conflict takes place every time the young doctor is asked to apply abortive intravenous infusions during a period of rotating internship, when he or she is asked about his or her independence from 'religious prejudices' before he or she can have access to programmess of specialisation, when during the period of training for specialisation he or she is forced to take part in stages of activity, foreseen in the curriculum of his studies, that require the performance of abortions or taking part in techniques of artificial fertilsation; when, after specialisation, he or she is refused jobs because they are reserved to personnel who will guarantee all the activities of the service, abortions included; when some career possibilities are closed to him or her because he or she does not have experience in all the professional fields that the managing role requires; and when, lastly, the agencies of the United Nations or of other funding centres refuse the requests of NGOs which do not include abortion and sterilisation among the methods for ensuring family planning in developing countries in their projects of international health care co-operation.

If to this we add the fact that in any case the Catholic obstetrician-gynaecologist faithful to the Magisterium of the Church is seen as a backward character, one cannot be surprised if everywhere Catholic obstetricians-gynaecologists are diminishing in number and in some situations risk disappearing completely.

Yet, this continuous, progressive decrease of Catholic obstetricians-gynaecologists seems to have taken place without provoking excessive alarm in the Church.

While, rightly, abortion has continued to be condemned, natural methods of planning have been proposed, the dangers for the future of human civilisation involved in embryo manipulation (for scientific purposes, for the cure of sterility, for the selection of carriers

of genetic illnesses, and for the production of stem cells) have been denounced, perhaps we have not sufficiently realised that the defence against these ills has become increasingly weaker as Catholic obstetricians-gynaecologists have disappeared and those remaining ended up by almost feeling guilty at their own convictions.

To whom in fact does a woman address herself in order to obtain information about how to control her fertility? From whom does she ask advice in order to solve difficulties in the couple's sexual life? Whom does she wish to talk to when an undesired pregnancy radically upsets her planes and those of her family? From whom does she ask help in order to overcome the ever more frequent cases of sterility?

The woman first of all seeks the help of a specialist doctor in obstetrics and gynaecology, a women's doctor. This doctor, in fact, is also their confidant, the keeper of their innermost secrets, perhaps even more so than the confessor.

A medical doctor who is respectful of the needs of morality and who is convinced of the Magisterium of the Church can help a woman to experience her doubts and difficulties in the light of faith. Only an obstetrician who is convinced of his or her own responsibilities as a counsellor and guide of a Christian woman can contribute to the strengthening of the family, to the culture of welcoming the newborn child as a gift. Only a Catholic obstetrician-gynaecologist can suggest the use of natural methods, can make the woman reflect upon the consequences of abortion, can advise her to adopt a baby rather than undergo IVF. Only a Catholic doctor specialised in obstetrics can make a valuable contribution to the sexual education of young women, and to the preparatory courses for marriage.

Only an obstetrician-gynaecologist can contribute to the education of future medical doctors and of future midwives in the respect of life. Only a medical doctor who loves life can promote research that is respectful of man.

It is for these reasons that the Catholic obstetrician-gynaecologist medical doctor must not disappear. We must be alert so as to ensure that this does not happen, so that the right to be trained and to exercise the profession according to conscience is respected; we must object every time this right is violated; we must help those who have suffered discrimination because they have borne witness to their loyalty to the teachings of the Church.

This is the appeal of the Pope in the encyclical *Evangelium Vitae* (no. 74): 'To refuse to take part in committing an injustice is not only a moral duty; it is also a basic human right. Were this not so, the human person would be forced to perform an action intrinsically incompatible with human dignity, and in this way human freedom itself, the authentic meaning and purpose of which are found in its orientation to the true and the good, would be radically compromised. What is at stake therefore is an essential right which, precisely as such, should be acknowledged and protected by civil law. In this sense, the opportunity to refuse to take part in the phases of consultation, preparation and execution of these acts against life should be guaranteed to physicians, health-care personnel, and directors of hospitals, clinics and convalescent facilities. Those who have recourse to conscientious objection must be protected not only from legal penalties but also from any negative effects on the legal, disciplinary, financial and professional plane.'

We must make this appeal ours and we must actively undertake works and initiatives that will make it effective. Some actions seem to be particularly necessary.

Local Churches have to keep their attention focused on the medical profession, proposing the ideal of a profession respectful of life, standing by those health workers who respect the right to life, and particularly obstetricians-gynaecologists, favouring their encounter and their self-expression at a cultural level.

The condemnation of cases involving the violation of the right to be trained and practice according to one's own moral convictions must be co-ordinated and systematic; it must reach the desks of the media, of professional associations, and of national and international organisations for the defence of human rights.

Catholic universities and hospitals must fully respect the indications of the Magisterium, both as regards research involving embryos and in all the spheres of obstetric-gynaecological practice, while bishops should feel responsible for monitoring matters so that examples of misconduct can be prevented, which, despite everything, continue to take place.

The same institutions should provide a qualified and internationally recognised teaching network to allow those medical doctors who are discriminated against or who are subjected to unacceptable pressures as regards their moral beliefs at least the possibility of specialising in obstetrics and gynaecology.

Dr. GIAN LUIGI GIGLI
President of the World Federation of Catholic Medical Associations, Member of the Pontifical Council for Health Pastoral Care

The Year 2001: The Activity of the Pontifical Council for Health Pastoral Care

Introduction

The work-plan for the Pontifical Council for Health Pastoral Care, which was created by the Plenary Assembly in 1998 and subsequently approved by the Holy Father, has fifty programmes organised around the Ministries of the Word, of Sanctification and of Communion, and is entrusted to the eighteen people who make up the Ministry - the Superiors, the Officials, and the collaborators. Employing this work-plan, the Pontifical Council in the year 2001 as well engaged in intense work directed towards 'expressing the solicitude of the Church for the infirm by helping those who engage in service to the sick and the suffering so that the apostolate of compassion that they await will answer in an increasingly better way to new needs' (*Pastor Bonus*, art. 152).

With regard to the Ministry of the Word, which has eleven programmes, the following actions were engaged in: an attempt was made to give a meaning to life and suffering, and to nature and its manipulation, explaining such meanings, disseminating them, and extending them to everyone, and in particular to those bishops who are responsible for pastoral care in health within their bishop's conferences. In this area, the celebration of the sixteenth international conference, the publication of the Pontifical Council's review *Dolentium Hominum*, the taking part in various congresses, conferences, and seminars by the Superiors and Officials of the Ministry, etc., proved to be of great help.

With regard to the evangelisation of the faculties of medicine, the Pontifical Council sought to keep in contact with the most important Catholic faculties of medicine, of pharmacy, and of law, in order to promote and secure the teaching of suitable courses in the future. The other programmes promoted in the sector of the Word with due commitment and endeavour related to: the publications of the Ministry, the World Health Organisation, the pastoral manual on drug-addicts, the guidebook on pastoral care in health, conferences, the international conference, research, teaching centres, and the Pontifical Council's special 'dossiers'.

In the ministry of sanctification, an attempt was made to *sanctify* the sick person and in general the world of health and health care by employing seven programmes of notable importance. These programmes involved: baptism, the anointing of the sick, other sacraments, the book of prayer and sacraments, the World Day of the Sick, prayers, and the 'Intention' of the Apostolate of Prayer.

In the ministry of communion, which has thirty-two programmes to develop, the aim was: to attain *solidarity-inspired communion* with sick people and health care workers throughout the Church. For this reason, the above-mentioned programmes sought to strengthen or achieve this solidarity-inspired communion. These were programmes which involved the Union of Catholic Medical Doctors, Nurses and Pharmacists and support for their associations in the world, above all at an international level. In this plan, which aimed at the unification of pastoral care in health throughout the world, of great importance as well was the creation of an International Union of Catholic Hospital Chaplains and the Union of Catholic hospitals. Reference should also be made here to the importance of the Union of Hospital Religious and the bishops responsible for pastoral care in health in their bishops' conferences. In addition, an attempt was made to increase the pastoral action of Catholic voluntary workers in the world of health care and to increase the number of, and expand, the associations of sick people. Amongst the various programmes in the sectors of communion, reference may be made to: the bioethical centres and the attempts made to achieve their unification; the organisation and the celebration of the World Day of the Sick; the universal right to health; the Christian communication of goods; emergency illnesses: AIDS, leprosy, and drug-addiction; the relations between the Ministries of the Roman Curia; the bishops responsible for pastoral care in health; the nunciatures; 'ad limina' visits, the Ministry's participation in, and representation at, congresses

and meetings outside the city of Rome, where it is located; pastoral visits and journeys, etc. In the work-plan account was also taken of the internal administrative programmes of the Ministry that form a part of the sphere of the sector of communion, that is to say: the secretariat, the administration, the archives' room, the documentation section, the keeping and cataloguing of documents and publications.

The above-mentioned fifty programmes were implemented

under the guidance of the President of the Ministry, H.E. Msgr. Javier Lozano Barragán, with due commitment and endeavour on the part of all the members of the Ministry. The results gave rise to great satisfaction.

In relation to this point, we would like to present in a more detailed fashion some of the salient features of the activity and the life of the Pontifical Council during the course of the whole of 2001.

1. Appointments within the Ministry

– On 20 August 2001 the Holy Father renewed *in aliud quinquennium* the appointment of H.E. Msgr. Javier Lozano Barragán, the Archbishop-Bishop Emeritus of Zacatecas, as the *President* of the Pontifical Council for Health Pastoral Care.

– By notes from the Secretariat of State, the Holy Father on 9 April 2001, confirmed *in aliud quinquennium* H.E. Msgr. José L. Redrado as *Secretary* of the Pontifical Council for Health Pastoral Care, and Rev. P. Felice Ruffini, M.I. as *Under-Secretary* of the same Pontifical Council until the age of seventy.

– By notes from the Secretariat of State, the Holy Father on 20 July 2001 appointed Rev. Krzsztof Jósef Nykiel, priest of the Archdiocese of Lodz (Poland), and Rev. Antonio Soto Guerrero, priest of the Diocese of Zacatecas (Mexico), both Officials of the Ministry, 'Chaplain to His Holiness'.

2. The Celebration of the Ninth World Day of the Sick

The Ninth World Day of the Sick of the year 2001 was solemnly celebrated in the Cathedral of St. Mary's in Sydney, Australia. 'The choice of the Australian continent with its cultural and ethnic richness', as the Holy Father observed in his special Message for this Day, 'illuminates the close tie of ecclesial communion: it goes beyond distances, favouring encounter between different cultural identities, fertilised by the unique proclaiming of salvation'. 'The evangelisation and the dignity of suffering man' was the subject of this Ninth World Day of the Sick, and its particular aim was to lay emphasis upon the need to evangelise this sphere of the human experience in a renewed way, in order to favour it being directed towards the overall well-being of the person and towards the progress of all people in every part of the world.

In the pontifical mission accompanying H.E. Cardinal Edward Clancy, the Special Envoy of His Holiness to the Ninth World Day of the Sick, were Rev. Krzysztof Nykiel, an Official of the Pontifical Council for Health Pastoral Care, Dr. John Callagher, and Judge John Slattery.

Archbishop Javier Lozano Barragán, President of the Pontifical Council for Health Pastoral Care, together with the Bishop-Secretary of the Pontifical Council, Msgr. José L. Redrado, O.H., led the delegation of a group of sixteen people: Officials of the Ministry, prelates, priests, religious and members of the laity 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 of the Pontifical Council for Health Pastoral Care, the Australian Bishops' Conference of Catholic Bishops, and the Episcopal Commission for Pastoral Care in Health. This convergent co-operation made possible not only a suitable preparation and celebration of this Day, but also its special sensitising force in relation to increasingly large numbers both of the lay faithful and of female religious and female laity who are active in the field of health and suffering.

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

Detailed information on this celebration can be obtained by readers in the review of the Pontifical Council, *Dolentium Hominum*, number 47/2001.

3. Participation in the Tenth Ordinary General Assembly of the Synod of Bishops

The President of the Ministry, H.E. Msgr. Javier Lozano Barragán, took part as an *ex officio* member in the above-mentioned assembly which took place in the Vatican from 30 September to 27 October. Its subject was *Epsicopus minister Evangelii Iesu Christi propter spem mundi*. The Pontifical Council contributed both to the preparatory stage and to the celebration of the Synod itself. The material drawn up and the contributions made by the President both in the conference hall and during the deliberations of the *circuli minores* on specific questions and issues met with the support of the Synod Fathers. They agreed on the importance of pastoral care in health and increasing the proclaiming of the Gospel of hope in the field of health and suffering by the pastors of the Church.

4. Inter-Ministerial Meetings

Within the context of the Ministry of Communion, the Pontifical Council strongly maintained and sustained its relations with the other Ministries of the Roman Curia, and took part in various inter-Ministerial meetings:

– At the Pontifical Council 'Justice and Peace' Rev. Krzysztof Nykiel, an Official of the Ministry, took part on 31 March in the inter-Ministerial meeting on preparations for the World Day of Peace (2002).

– At the Pontifical Council for Culture on 11 May Rev. Antoni Soto, an Official of the Ministry, took part in the inter-Ministerial meeting on the subject: 'cultural identity in the era of globalisation: nostalgic temptation or challenge for the Church'.

– At the Pontifical Council for Inter-Religious Dialogue Rev. Krzystof Nykiel, an Offi-

cial of the Ministry, took part on the morning of 1 June in an inter-Ministerial meeting and presented a number of observations on the draft version of the document entitled: 'A Christian Spirituality of Inter-Religious Dialogue'.

– At the Pontifical Council for the Family from 27 to 28 June the Secretary of the Ministry, H.E. Msgr. José L. Redrado, took part in an inter-Ministerial meeting with a group of members of the European Parliament in order to examine certain subjects and issues relating to the family as well as connected ethical questions, and to examine subjects and issues connected with human life.

5. Participation in, and Representation at, Conferences, Congresses and Celebrations

Another programme of the Ministry of the Word was participation in, and representation at, conferences, congresses and celebrations. The Superiors and Officials of the Ministry were involved in these throughout the year 2001:

MARCH

– On 13 March Rev. Krzysztof Nykiel took part, as a representative of the Ministry, at the 'Colloquium' on Prof. Gesulado Nosengo, which was organised by the Pontifical Urbanian University.

– On 14 March, in Rome, on the occasion of the pastoral meetings held during the period of Lent, the Secretary of the Ministry, H.E. Msgr. José L. Redrado, gave a paper on the subject: 'accompanying life in weakness: illness and death'.

– From 20 to 23 March, in the Vatican, H.E. Msgr. Javier Lozano Barragán, the President of the Ministry, took part in the plenary meeting of the Pontifical Commission for Latin America and gave a paper on the subject: 'Indios Theology'.

APRIL

– From 2 to 4 April, at Hammamet (Tunisia), Dr. Renzo Paccini, a collaborator of the Ministry, took part as a representative of the Pontifical Council in the First Mediterranean Congress on Disability, which had been organised by the 'Opera Don Guanella' in conjunction with the Ministry for Social Affairs of Tunis, the Church of Tunisia, and the 'Oasi Federico' Association for Solidarity and Rehabilitation Studies of Calabria. It may be observed that Calabria is a hinge region for the Mediterranean. Dr. Paccini gave a paper on the subject: 'human dignity in disabled people: a point of departure for solidarity towards them'.

– On 26 April, in Rome, Rev. Krzysztof Nykiel, an Official of the Ministry, took part as a representative of the Pontifical Council in the national conference of pre-surgical dentistry organised by the Italian Society of Odontostomatology and Maxillo-Facial Surgery (SIOCMF) under the patronage of the 'College of Lecturers in Dentistry' under the Presidency of Prof. Giovanni Dolci, and gave an address of greeting to the participants.

MAY

– From 7 to 11 May, in Barcelona, the President of the Ministry, H.E. Msgr. Lozano Barragán, and the Secretary, H.E. José L. Msgr. Redrado, took part in the twelfth national congress of hospitals on the subject 'El hosptal y la salud, más allá de la gestión' organised by the Federación Española de Gestión Sanitaria. The President gave a paper on the subject: 'Aportes para la identidad de un hospital católico'.

– From 10 to 12 May, in Fiuggi, Rev. P. Felice Ruffini, M.I. Under-Secretary of the Ministry, took part in the national conference on 'the Italian Church in the world of health and health care' organised by the National Office for Pastoral Care in Health of the Italian Bishops' Conference, and gave an address of greeting to the participants.

– From 14 to 16 May, in Paris, the Official of the Ministry, Rev. Msgr. Jean-Marie Mpendawatu, took part as an Observer of the Holy See in the Second Session of the Intergovernmental Committee on Bioethics of UNESCO.

– From 15 to 22 May, in Geneva, the President of the Ministry, H.E. Msgr. Javier Lozano Barragán, took part as head of the delegation of the Holy See, in the fifty-fourth session of the World Assembly on Health Care, and presented during his speech a 'position paper' of the Holy See on access to basic medicines for the poorest populations of the world and on the juridical and economic structures, including intellectual property rights, which can obstruct such access. Rev. Msgr. Jean-Marie Mpendawatu, an Official of the Pontifical Council, was also a member of this delegation.

JUNE

– From 1 to 4 June, in Lodz and Krakow, accompanied by Rev. Krzysztof Nykiel, an Official of the Ministry, H.E. Msgr. José L. Redrado, in response to an invitation extended by Frà Ambrozy Pietrzkiewicz, Provincial of the Polish Province of the Fatebenefratelli, presided over a concluding concelebration of the Eucharist on the fourth centenary of St. John the Great with a homily suitable to the occasion and took part in the symposium on pastoral care in health on the subject of 'the terminally-ill sick person amongst us'. Both in Lodz and in Krakow the President of the Pontifical Council visited the hospital structures of the Order and met medical staff and personnel, and members of the community of the Fatebenfratelli. H.E. Redrado held three conferences on the following subjects: 'the hospitality of the Fatebenefratelli at the beginning of the third millennium', 'the faces of suffering and death', and 'consecration, koinonia, and mission'.

– From 5 to 7 June, in Puebla de los Ángeles (Mexico), H.E. Msgr. Javier Lozano Barragán took part in the meeting of the Members and Consultors of the Pontifical Council for Culture, as well as the First American Intercontinental Conference of the Presidents of the Episcopal Commission for Culture of the Bishops' Conferences of America. He gave a paper on the subject: 'Globalización de la salud en la sociedad secularizada: retos para Evangelización de la cultura'.

– On 7 June, on the occasion of the feast of San Camillo de Lellis, H.E. Msgr. Redrado presided, at the San Camillo hospital in Rome, over a cele-

bration of the Eucharist and gave a homily which stressed the extraordinary importance of San Camillo di Lellis and Santa Giovanna Antida Thouret.

– From 25 to 27 June, in New York, the President of the Ministry, H.E. Msgr. J. Lozano Barragán, took part, as head of the delegation of the Holy See, in the special session of the General Assembly of the United Nations dedicated to the questions and issues connected with HIV/AIDS, and presented the position of the Holy See on such questions and issues. Rev. P. Felice Ruffini, the Under-Secretary of the same Ministry, was also a member of this delegation.

JULY

– On 7 July, in Rome, H.E. Msgr. Javier Lozano Barragán took part in the proceedings and deliberations of the Sixth General Assembly of the Pontifical Academy for Life on the subject: 'human nature and natural law as a foundation of the right to life'.

AUGUST

– From 26 to 29 August, in Seoul (Korea), accompanied by Rev. Antonio Soto, an Official of the Ministry, H.E. Msgr. Javier Lozano Barragán took part in the eighth regional conference of the Asian continent of the International Catholic Committee of Nurses and Medical-Social Workers (CICIAMS) which was held on the subject: 'the protection of human life in a changing world: the responsibility of the Catholic heath care worker'. The President of the Pontifical Council gave a paper on 'the protection of human life in a changing world: the responsibility of Catholic obstetricians'.

SEPTEMBER

– From 1 to 8 September, in Taipei (Taiwan), accompanied by Rev. Antonio Soto, an Official of the Ministry, H.E. Msgr. Lozano Barragán took part in the meeting of Catholic medical doctors, nurses and medical students organised by the management of the St. Mary's hospital of Loutung of the Camillian fathers, on the occasion of the fiftieth anniversary of the missionary presence of Camillians in Formosa. The President gave a paper on the subject: 'the protection of human life in a changing world: the responsibility of health care professionals'. In addition, H.E. Msgr. Lozano Barragán visited the various institutions of the Camillians, met the medical staff and personnel of the hospital in Lotung, as well as the sick, and the whole of the Camillian community.

– From 10 to 11 September, in Rosario (Argentina), the President of the Ministry, H.E. Msgr. Lozano Barragán, took part in the first conference of hospital chaplains, organised by the Episcopal Commission for Pastoral Care in Health of Argentina, which focused on the following subjects: 'Los Professionales de la Salud, Servidores de la Vida', 'El Capellán: su perfil y la presencia en el Centro de Salud', 'Ejercicio de la Capitalidad de Cristo en al accion pastoral del Capallán', and 'La formación especifica del Capellán a través de las Asociaciones y Fraternidades'.

– From 13 to 15 September, in Rio de Janeiro (Brazil), accompanied by Dr. Renzo Paccini, a collaborator of the Ministry, H.E. Msgr. Lozano Barragán took part in the third Brazilian congress of Catholic medical doctors on the subject 'Vida Humana, Ciencia y etica', which had been organised by the Federation of the Latin American Associations of Catholic Medical Doctors (FAMCLAM). The President of the Ministry held a conference on the subject: 'Identidad y Ministerio del Médico Católico'.

– From 24 to 27 September, in Madrid, H.E. Msgr. José L. Redrado took part in the Sixteenth National Day of Pastoral Care in Health on the subject: 'Orar en la Enfermadad', which had been organised by the Episcopal Commission on Pastoral Care in Health of the Bishop's Conference of Spain. The Secretary of the Pontifical Council gave a paper under the heading: 'Lord: teach us how to pray (Lk 11:1-4)'.

– From 27 September to 1 October, H.E. Msgr. José L. Redrado, the Secretary of the Ministry, went to Mexico City and took part in the commemorative ceremonies to mark the 'centenary of the restoration of the Order of St. John of God in Mexico by San Benedetto Menni'. He presided in the Sanctuary of Our Lady of Guadalupe over the concluding solemn concelebration of the Eucharist and gave a homily on that occasion. In addition, the Secretary of the Pontifical Council held two conferences on the following subjects: 'life, illness, and death' and 'consecration, koinonia, and mission'.

OCTOBER

– From 9 to 13 October, in preparation for the celebration of the Tenth World Day of the Sick, accompanied by Rev, Vincent Arackal, a collaborator of the Ministry, H.E. Msgr. Lozano Barragán and H.E. Msgr. José L. Redrado went to the sanctuary of the 'Madonna of Health' in Vailankanny (India). A series of meetings were held

with the Episcopal Commission for Pastoral Care in Health and the organising committee.

NOVEMBER

– From 10 to 13 November, in Rome, Rev. Krzysztof Nykiel, an Official of the Ministry, took part as a representative of the Pontifical Council at the Colloquium on the subject: 'prayer for healing and charismatic renewal in the Catholic Church' which had been organised by the Pontifical Council for the Laity together with the International Catholic Charismatic Renewal Services (ICCRS).

– On 13 November, in Rome, the President of the Ministry, S.E. Msgr. Javier Lozano Barragán, inaugurated the deliberations and proceedings of the round table on the subject: 'community and health' which had been organised by the 'Camillianum' International Institute for the Theology of Pastoral Care in Health.

– From 22 to 24 November, in the Vatican, Rev. Krzysztof Nykiel, an Official of the Ministry, took part as a representative of the Pontifical Council in the theological-pastoral congress on the subject: '*Familiaris Consortio* yesterday and today on its twentieth anniversary: the anthropological and pastoral dimension', which had been organised by the Pontifical Council for the Family.

– On 23 November, in Rome, Dr. Renzo Paccini, a collaborator of the Ministry, took part as a representative of the Pontifical Council in the first conference of the Federation of the Associations for Assistance to Disabled People.

DECEMBER

– On 15 December, in Rome, the Secretary of the Ministry, H.E. Msgr. José L. Redrado, presided over a celebration of the Eucharist at the inauguration of the school year of the 'Beato Luigi Tezza' nursing school, and gave a homily at the time of that celebration.

– On 21 December, in preparation for the Christmas celebrations, H.E. Msgr. José L. Redrado presided over a celebration of the Eucharist in the Basilica Liberiana di Santa Maria Maggiore for the members of the Norman Academy.

6. The Sixteenth International Conference

From 15 to 17 November the sixteenth international conference promoted and organised by the Pontifical Council for Health Pastoral Care was held in the New Hall of the Synod. The subject of this sixteenth international conference was 'health and power'.

Under the guidance of H.E. Msgr. Javier Lozano Barragán, the President of the Ministry, Cardinals, Archbishops, Bishops, male and female religious, and members of the lay faithful, from sixty countries, came together to attend this international conference. All these people were involved in the world of health, health care and suffering and/or were specialised in the various disciplines of the humanistic, social, biomedical and theological-pastoral sciences.

A large number of ambassadors and Ministers of Health, numerous students from medical schools, and a large number of students of the nursing sciences, and of the theology of pastoral care in health, took part in the proceedings and deliberations of this international conference.

Amongst the distinguished speakers at the international conference were: Cardinals, Bishops, eminent researchers, and scientists and scholars of the humanistic, social, biomedical and theological-pastoral sciences.

The President of the Ministry, H.E. Msgr. Javier Lozano Barragán, introduced the proceedings and deliberations of the conference, and His Eminence Cardinal Fiorenzo Angelini, the President Emeritus of the same Ministry, opened this important annual conference with an inaugural address on 'health and power in the light of the word of God'.

The general subject 'health and power' was addressed by various speakers in the light of the word of God and theology so as to bring out the contemporary biomedical challenges to health and health care which come from the power of the economy, of politics, of the sciences, of technology, of culture and of society, as well as to consider the moral requirement of a power which, respecting the truth about man and God, and in its exercise respecting charity towards one's neighbour in need, serves the health of man and of peoples in their harmonious movement towards the fullness of life.

During the proceedings and deliberations of the conference the eminent speakers focused in on the following subjects: the power of the economy in the world of health; power and health care policy; power, health and society; the power of the mass media; the power of health care workers; the power of the pharmaceutical industries; the power of international organisations; religious power and health; power and health in the context of inter-religious dialogue with Judaism, Islam, Hinduism and Buddhism; and power and health in history and in theology.

The participants at the conference were received by the Holy Father at an audience held in the Paul VI Hall. In an authoritative address John Paul II emphasised among other things that 'in the world of health, the exercise of power should not be inspired by the wish for dominion or profit but should be animated by a sincere spirit of service to the dignity of the human person and the common good'.

The Holy Father also emphasised that health understood as physical, mental and spiritual health, and as health care, is the first, the most authentic, universal and greatest power, because it is a force directed towards the fullness of life; and to understand and live out correctly every form of 'power' in the world of health one must fix one's gaze upon Christ who came not to be served but to serve, thereby teaching us to exercise every form of power as service to our neighbour.

7. The International Symposium on Catholic Voluntary Work in Health Care on the theme 'Vade et tu fac Similiter'

With the aim of achieving the unification of pastoral care in health throughout the world, the Pontifical Council for Health Pastoral Care promoted and organised an international symposium on 'Catholic voluntary work in health care'. This took

place in the Vatican on 30 November to 1 December 2001.

The celebration of this important symposium, strongly wished for specifically in the year 2001, which the United Nations had officially declared as the International Year of Voluntary Work, was a valuable opportunity for a new and more involving reflection on an aspect of service to life which, in the Church, following the example of Christ, has found, from the outset, a new and exemplary impulse.

Under the guidance of the President of the Ministry, His Excellency Msgr. Javier Lozano Barragán, an attempt was made to engage in a careful reflection on the role of *Catholic voluntary work* in the world of health and suffering today; to identify future strategies by which to increase pastoral action; and above all else to offer to the Holy Father an opportunity to emphasise the fundamental principles by which to illuminate this gospel-inspired form of participation in the suffering of one's neighbour, specifically during the year dedicated by the United Nations to voluntary work.

Amongst the distinguished speakers who intervened during the two days of reflection and witness from life experience, there was the Secretary of State, His Eminence Cardinal Angelo Sodano, who opened this important event with his opening address on the subject 'Catholic voluntary work in health care'. The representatives of States and governments also took part in the deliberations of the symposium, as well as a large number of voluntary-work associations.

The general subject of 'Catholic voluntary work in health care' was addressed by various speakers in the light of the word of God, theology, and the Magisterium of the Church so as to bring out the major challenges for voluntary workers, and especially those who work in the field of health. The witness and life-experiences of a number of voluntary workers, who are involved in a large number of forms of solidarity and work in the name of the Church at the side of the poor and the suffering, were not absent.

The distinguished speakers at the symposium focused in on the following subjects:

– The Magisterium of John Paul II on voluntary work.

– The biblical and theological foundations of voluntary work.

– From the Good Samaritan to the Ecclesial Community of the third millennium.

During the 'round table' discussion certain important forms of witness based on life-experiences were communicated one after another: by a sick person, a medical doctor, a voluntary worker, representatives of the 'Misericordie' and of the Red Cross, etc.

The first day of December 2001 coincided with the World AIDS Day and was dedicated to reflection upon health care given to people suffering from AIDS; to people who live in very bad conditions in cities - the homeless, drug-addicts...; to emigrants and refugees; to people who are the victims of political conflicts and wars; to people afflicted by catastrophes such as earthquakes and floods; to the elderly, to the terminal ill, and to children, whether they are in public or private institutions or live in their own homes.

The large number of participants were received by the Holy Father in an audience held in the Paul VI Hall. In his authoritative address the Holy Father emphasised that in our society, which often feels the influence of materialism and hedonism, the vitality of voluntary work is a promising sign of hope. The presence of *voluntary work* must be more than ever before animated and experienced in its truth of selfless service to the good of people, especially those most in need and most forgotten about by the social services themselves. Voluntary work is specifically marked out by its capacity to bear witness to freely-given love to one's neighbour.

The Holy Father also emphasised that in order to understand, promote and live out every form of voluntary action, especially in the world of health and suffering, it is essential to fix one's gaze on the Countenance of Christ, who is the perfect model for Christian *voluntary work*. He who came not to be served (cf. Mt 20:28) but to serve teaches us that the service of voluntary workers is a service of freely-given love to the person, especially if he or she is weak or fragile. It is he who took on painful humanity in order to restore to it the transfigured countenance of the resurrection. With their gaze fixed on Christ, Christian voluntary workers are bearers of hope, in the bitter experience of suffering and precariousness as well, fully respecting the dignity of every human being. Catholic voluntary work is called upon to base its strategy on *the charity of works*, the real point of encounter for service to charity and an effective instrument for the credibility of the Gospel of Christ.

The service of *voluntary work* is service to life, and as such is a providential space for intercultural dialogue and co-operation with voluntary workers of other religions or who are non-believers, because the defence and promotion of life is entrusted to everyone.

8. Publishing Activity

Publishing activity is a part of the programmes of the ministry of the Word. We would like above all else to point in this context to the journal of the Ministry, *Dolentium Hominum. Church and Health in the World*, which came out regularly. It is offered to readers in four separate language editions (Italian, Spanish, French and English). One of its issues contains the complete proceedings of the fifteenth international conference organised and promoted by the Pontifical Council on the subject 'health and society'.

The *Charter for Health Care Workers*, which was published in 1994 in Italian as a result of the efforts of the Ministry, has so far been translated and published by different countries in the following languages: Spanish, English, French, German, Dutch, Polish, Russian, Czech, Slovene and Rumanian. With the *nulla osta* of the Pontifical Council the publication of the *Charter for Health Care Workers* in Hungarian and Lithuanian is also underway. This work is also currently being translated into Madagascan, Albanian, and Thai.

Four editions in Spanish (two in Mexico, one in Peru, and one in Colombia) have been issued of the book by the President of

the Ministry, H.E. Msgr. Javier Lozano Barragán, *Telogia e Medicina* ('Theology and Medicine'), as well as an edition in Italian (Edizioni Dehoniane, Bologna).

The *Manuale di Pastorale: Chiesa, Droga e Tossicomania* ('A Pastoral Guidebook: the Church, Drugs, and Drug-addiction'), written by the Ministry, was also published. It is directed, as requested by the Holy Father, to bishops, priests, male and female religious, and members of the laity involved in pastoral care for drug-addicts. An edition in English is currently being prepared.

9. Various

The year 2001 was also a year of high recognition and acknowledgement of the work of the Pontifical Council for Health Pastoral Care:

– On 5 September the President of the Ministry, H.E. Msgr. Javier Lozano Barragán, received an 'honoris causa' doctorate in theology from the 'Fu Jen' Catholic University of Taiwan.

– On 6 October the Secretary of the Ministry, H.E. Msgr. José L. Redrado, was appointed one of the members of the Norman Academy as Grand Spiritual Prior.

10. Conclusion

The above-mentioned programmes of the work-plan of this Pontifical Council involved, in the first instance, the Superiors, Officials and internal and external collaborators of the Ministry. At the headquarters of the Pontifical Council in Rome activity was very intense. Meetings were held to prepare and organise congresses and conferences, and inter-Ministerial meetings with experts were held within the context of study work-groups to examine the problems of drugs, AIDS, AISAC, the guidebook for pastoral care in health, the book of prayers and sacraments, etc.

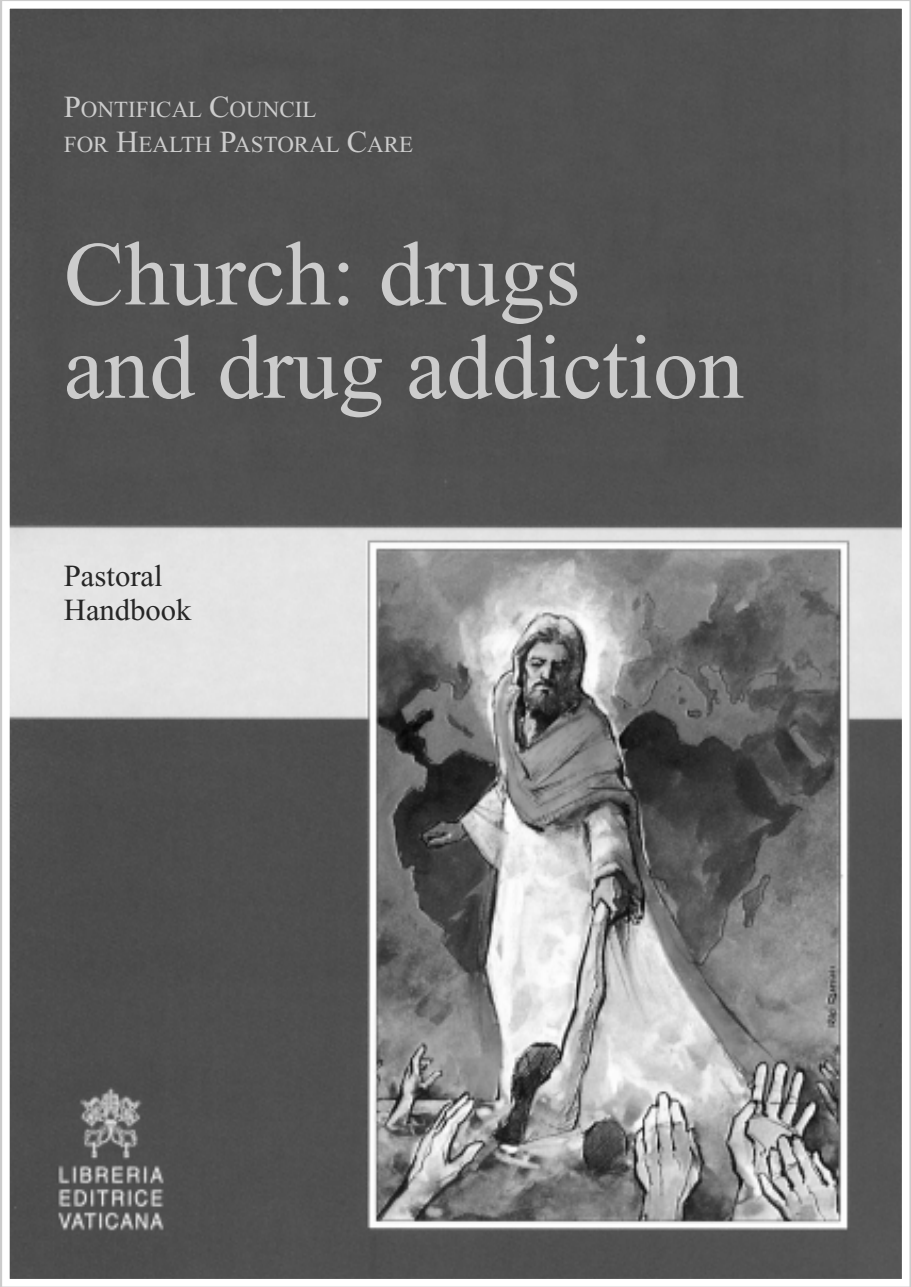
During the year 2001 the epistolary correspondence between the Pontifical Council for Health Pastoral Care and local Churches, pontifical representatives (and in particular newly appointed such representatives), bishops, priests, and members of religious Orders, civil and health care political authorities, ambassadors, heads of organisations and associations of the world of health, and all those who work in the vast field of pastoral care in health, was also continued.

The meetings with bishops who were on *ad limina* visits were of great help because they allowed the Pontifical Council to have a more direct knowledge of the various problems of pastoral care in health of the local Churches, a *sine qua non* in order to be able to offer relevant co-operation regarding the needs of the dioceses and of bishops' conferences.

Co-operation with the pontifical representatives was once again valuable both because of the work of sensitisation in relation to health care problems within the respective legations and because they acted as a channel for communications, initiatives, and consultations between the Pontifical Council and the bishops' conferences.

As a result of this shared commitment, many initiatives were implemented. Others will be continued in 2002.

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



What should be done in the pastoral field with respect to the drug problem? Many bishops, priests, religious men and women, anguished parents, addicted youths and non addicts, have asked themselves: What can we do as Christians, faced with the drug problem? With this Handbook, the Pontifical Council for Health Pastoral Care does not claim to offer a definitive answer, bu it seeks to give suggestions that could help in the pastoral work; we do not herewith intend to propose a new method, but to offer a simple answer, in the form of a practical guide, to basic questions for pastoral action and which perhaps will also be of service to those who through much dedication and care have become specialists in this field. The Holy Father indicated to us three actions in dealing with the drug problem: prevention, care and suppression of the traffickers of death ; here we only deal with the first two, leaving to the Governments to confront with courage the multifaceted figth against drugs, one to which we should all be united.

For the purchase of this volume in english, € 9 (which will be available beginning with June 2002) apply to the Libreria Editrice Vaticana - 00120 Vatican City